

ASSESSING VA'S ABILITY TO PROMPTLY PAY NON-VA PROVIDERS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

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ASSESSING VA'S ABILITY TO PROMPTLY PAY NON-VA PROVIDERS

Wednesday, June 3, 2015

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON HEALTH,
Washington, DC

The subcommittee met, pursuant to notice, at 10:00 a.m., in Room 334, Cannon House Office Building, Hon. [chairman of the subcommittee] presiding.

Present: Representatives Benishek, Huelskamp, Coffman, Wenstrup, Abraham, Brownley, Takano, Ruiz, and Kuster.

Also Present: Representative Walorski.

OPENING STATEMENT OF CHAIRMAN DAN BENISHEK

Dr. BENISHEK. Good morning. The subcommittee will come to order.

Thank you all for joining us for today's subcommittee hearing, "Assessing VA's Ability to Promptly Pay Non-VA Providers."

The issue we will discuss this morning, VA's ability to efficiently and accurately reimburse non-VA providers for the services they provide to veteran patients on the Department's behalf, has perhaps the most far-reaching implication of any issue that we will discuss this Congress. It impacts small and large hospital systems, individual providers and practice groups, ambulance companies and emergency departments, home health aides, mobility equipment dealers, and all manner of others in communities across the country who find themselves left holding VA's check, sometimes to the tune of millions of dollars.

It impacts veterans, who are sometimes billed for services that VA should have paid, which can damage both their credit and their confidence in VA. And it also impacts the overall success of VA healthcare system—a healthcare system that is increasingly reliant on non-VA providers who are becoming more and more hesitant to accept veteran patients for fear that VA will not reimburse them for the services that they provide.

This morning, we will hear troubling testimony from some non-VA providers who will outline persistent difficulties that they have faced when attempting to obtain timely and accurate payment from VA, overly burdensome VA guidelines that hinder their ability to resolve issues with VA officials, and inexplicable gaps between stated VA policy and day-to-day practice in the field.

They will allege that they are owed, in some cases, tens of millions of dollars over many years and have to fight VA for every

penny. They will allege that they have had to wait for up to 4 hours on the phone when attempting to contact VA to check on the status of a claim and then, after connecting with a VA employee, were disconnected because they did not know the veteran's middle name or tried to ask VA about more than four claims on one phone call.

Perhaps most disturbingly, they will allege that VA has lost sensitive medical documentation that they have provided to support their claims even though they are able to demonstrate via certified mail that VA received the documents in question.

What worries me almost more than the testimony that we will hear today is the testimony that we won't hear today from those who are reluctant to share their stories publicly out of fear of retaliation. For example, a small business in my district who has been unable to obtain timely payment from VA for services provided to Michigan veterans elected not to provide comments for today's hearing out of fear that coming forward would negatively impact their relationship with VA leaders and, therefore, their ability to get paid for the services that they have rendered so far and to continue helping veterans in the future.

Of course, all of this begs questions. If non-VA providers are owed collectively hundreds of millions in backlog payments, where is that money? Why is there such a wide variation in claims processing from VA facility to VA facility? And why are there such burdensome restrictions placed on non-VA providers, who are simply looking to be reimbursed in a timely manner for the valuable life-saving services that they provide?

What retaliatory actions has VA taken against non-VA providers that have caused many to be unwilling to publicly relay their stories? How can VA expect to become a healthcare leader when basic business functions cannot be completed efficiently? And, most troublingly, what happened to medical record information that VA is signing for and then claiming never to have received? And how can we be sure that sensitive, personal information has not been compromised by shoddy VA recordkeeping?

These are just some of the many serious issues that we need answers to this morning.

So, without further ado, I now yield to Ranking Member Brownley for any opening statements she may have.

OPENING STATEMENT OF RANKING MEMBER JULIA BROWNLEY

Ms. BROWNLEY. Thank you, Mr. Chairman. And thank you for calling this hearing today.

Section 105 of the Veterans Access, Choice, and Accountability Act required the Veterans Affairs to set up a claims processing system. In addition, the Government Accountability Office is to report it to us no later than 1 year after the law was enacted about the timeliness of payments for hospital care, medical services, and other health care furnished by non-Department of Veterans Affairs healthcare providers. I understand the report is due August 7 of this year, and I look forward to receiving the report from GAO.

The VA has struggled in the past to ensure that non-VA providers are paid in a timely manner. Numerous past reports by the

GAO have found weaknesses in the management and oversight of non-VA medical care.

In today's testimony submitted by Mr. Greg Hufstetler of EmCare, he claims that EmCare has been unable to obtain virtually any payments from the Veterans Health Administration since the fourth quarter of 2013.

I understand that EmCare has treated over 59,000 veterans without receiving payment. This concerns me greatly. I look forward to hearing from VA how this could happen and what are they doing to address the situation. Is this typical throughout the healthcare system, or are there extenuating circumstances involved in this particular instance?

According to VA testimony, since May of 2014, VA has received 34 percent more claims than January 2015 through April of 2015 as compared to the same time in 2014. That represents a significant increase of claims into a system that was already overburdened. I would like VA to tell the subcommittee what the significant challenges are that affect the ability of VA to pay on time.

Mr. Chairman, again, I want to thank the witnesses for being here today to help inform the subcommittee how we can improve the claims processing system of the Veterans Health Administration. I look forward to their testimony, and I thank you for holding the hearing.

And I yield back.

Dr. BENISHEK. Thank you, Ms. Brownley.

Joining us on our first and only panel this morning is Asbel Montes, vice president of reimbursement and government affairs for Acadian Ambulance Service; Vince Leist, president and chief executive officer of the North Arkansas Regional Medical Center, who is testifying on behalf of the American Hospital Association; Dr. Gene Migliaccio, VA's Deputy Chief Business Officer for Purchased Care, and he is accompanied by Joseph Enderle, VA's Director of Purchased Care Operations. We are also joined by Sam Cook, president of the National Mobility Equipment Dealers Association.

I am going to yield to his Congresswoman, my friend, colleague, and fellow committee member, Jackie Walorski, to introduce him.

Mrs. WALORSKI. Thank you, Mr. Chairman, for the opportunity of allowing me to introduce my constituent Sam Cook, president of Superior Van & Mobility in South Bend, Indiana, located in my district.

Sam's father, Dan Cook, Sr., founded Superior in 1976. It is a family-run business and today is currently one of the largest mobility dealers in the country. Along with running a growing company, Sam has acted with the National Mobility Equipment Dealers Association, where in 2012 he assumed the role of president of the board of directors.

I would like to welcome Sam and thank the chairman for the indulgence.

Dr. BENISHEK. Thank you, Mrs. Walorski.

Well, let's begin.

Mr. Montes, we will begin with you. Please proceed with your testimony. You have 5 minutes. Thanks.

STATEMENT OF ASBEL MONTES

Mr. MONTES. Chairman Benishek and Ranking Member Brownley and distinguished members of the subcommittee, my name is Asbel Montes, and I am the vice president of reimbursement and government affairs for Acadian Ambulance Service. We are located in Lafayette, Louisiana. We are the largest privately owned, employee-owned ambulance service in the Nation.

The chairman and CEO of our company, Richard Zuschlag, founded our company in 1971 with eight Vietnam veterans. Today, we have over 4,000 employee-owners, with over 400 of those being military veterans. So I am honored to sit before you today to represent not only our industry but, even more so, the veterans that we serve.

Prior to coming before you today, our company, along with American Medical Response, who is the largest public ambulance provider in the Nation, and the American Ambulance Association have worked diligently with our congressional delegation, our other healthcare stakeholders, the Veterans Integrated Service Network, as well as the national leadership at VA to assist, recommend, and, frankly, demand that VA's internal processes be updated and modified to ensure that they are fulfilling their intended purpose but also not placing a financial burden on the men and women who have served our Nation so selflessly. Despite these efforts, we have not seen any significant positive movement from VA and, therefore, find ourselves here today.

For a real-life look at the issue, please allow me to provide one example that a veteran in Louisiana experienced who called 9/11 for emergency medical care and transport in early 2014.

We filed a claim and provided all the necessary information and medical records and appropriate documentation within 30 days to VA. We sent this information via certified mail. VA signed for it, confirming receipt, 5 days later. Almost a year later, on March of 2015, the veteran appeared on two local TV channels describing how his claim was still unpaid. He was subsequently contacted by a VA representative on March the 18th of 2015 indicating that his claim would be paid and he would receive notification. The claim finally processed on April of 2015, over a year and 3 months later.

There are many more examples just like this that we could provide you of other providers and veterans alike across the Nation, but suffice it to say the GAO report in 2014, which highlighted these issues regarding excessive claims processing time and paperwork requirements for non-VA providers, is absolutely correct.

This problem is especially acute for the majority of ambulance services, providers that serve the local 9/11 responders and their communities, who are prohibited from refusing emergency treatment from any patient regardless of their payer source and the ability to pay.

The failure to pay providers in a timely and accurate manner puts providers like us in the difficult position of having to bill veterans for emergency treatment, placing an unfair financial burden on the veterans due to the lack of response, invalid denial or payment by VA.

Our previous efforts at addressing this issue have included numerous increase sent from our Congressmen and Senators in many

States, and the responses from VA have remained wholly inaccurate and inadequate.

My colleagues and I are not ignorant to the magnitude that this issue presents for VA. However, after numerous offers of assistance and requests for relief from the private and public sector, we have seen very little change. In fact, our company, American Medical Response, and many members of the American Ambulance Association have seen a recent escalation of the problem, with our accounts receivable due from VA growing in excess of \$30 million over 90 days.

VISN 16 has sent reports to our congressional delegates with a number that would indicate improvement, but our data clearly indicates the opposite. On May 14 of this year, just a few weeks ago, we had yet another conference call with VISN 16, specifically the Flowood, Mississippi, office, and requested that they provide us with all claims that we filed to them since 2012 in order to reconcile our records with theirs.

That audit, which we completed last Tuesday, indicated that they showed no record of 768 claims which were sent certified mail with confirmation of receipt. Last Thursday, just a few days ago, they said they would investigate the discrepancy and get back with us on Friday. As of this morning, when I spoke with my staff at 9 o'clock, we still had not heard from their office regarding that.

The Federal Government has a responsibility to ensure that our veterans receive the best health care we can provide. It also has the responsibility to ensure that they are not required to bear an unjustified financial burden because VA fails to pay non-VA providers in a timely and accurate manner.

It is our recommendation that Congress remove all claims processing for non-VA providers from the Department of Veterans Affairs and place it with a single fiscal intermediary, providing guidelines and policies to address the issues stated here today. These steps would ensure consistency, efficiency, and expertise in personnel, as well as sufficient, dedicated resources to process claims timely. Several other government programs, such as TRICARE and Medicare, utilize this strategy successfully, but note that time is of the essence.

Thank you for giving me this opportunity to provide this information and serve those who have sacrificed so much for our Nation. I look forward to answering the committee's questions and serving as a resource as the committee's work continues beyond this hearing.

[THE PREPARED STATEMENT OF ASBEL MONTES APPEARS IN THE APPENDIX]

Dr. BENISHEK. Thank you, Mr. Montes.
Mr. Leist, please go ahead.

STATEMENT OF VINCE LEIST

Mr. LEIST. Thank you.

Chairman Benishek and Ranking Member Brownley, on behalf of the American Hospital Association's nearly 5,000 member hospitals, health systems, and other healthcare organizations, I thank you for the opportunity to testify today.

I am Vince Leist. I am president and CEO of North Arkansas Regional Medical Center. We are a county-owned facility that is operated by a separate 501(c)(3), a not-for-profit organization, serving the comprehensive healthcare needs of rural communities of four counties in north-central Arkansas. Like every community in America, we are proud of the men and women who have served our great Nation, and we are honored to care for them in their time of need.

America's hospitals strive to ensure patients get the right care at the right time in the right setting. We have a longstanding history of collaboration with VA and are eager to assist the Department and our veterans in any way that we can.

However, hospitals' continued inability to obtain a timely payment from VA and its contractors hinders access for care for veterans who need non-VA services and undermines the ability and viability of non-VA hospitals and the essential services they provide to their communities.

We also are concerned about the process in which VA processes claims. Medical records have been lost or unaccounted for, leading to questions about the privacy of our veterans' records. In addition, many veterans worry about their claims that are not paid promptly or left unpaid completely, and they are left in a difficult position of trying to get their claims paid while they are battling illness. This is an untenable position for both the hospital and for the veterans.

Last month, at a hearing before the House VA Committee, VA Deputy Secretary Sloan Gibson acknowledged the lack of timeliness in promptly reimbursing non-VA hospitals and expressed his commitment to improve the payment process. Hospitals and health systems welcome this commitment. However, many non-VA hospitals have outstanding payments spanning many months, some dating back years.

While North Arkansas Regional Medical Center is very dedicated to serving the veterans in our community, we accept each and every one who walk through our door. We have decided against contracting with VA due to slow or no payment for claims and the bureaucracy involved in getting reimbursement for claims.

Since 2011, we have had 215 claims, totaling more than \$750,000, that have not been paid by VA. We have attempted to work with VA to resolve these claims. However, those efforts have resulted in long periods on hold to speak to VA representatives, limitations on the number of cases that can be discussed in any one particular phone call, and, once again, countless lost medical records.

In addition, according to data from the Arkansas Hospital Association, more than 4,400 claims, many dating back 3 years, totaling more than \$24 million, are currently owed 60 hospitals in the State of Arkansas. In March, VA reported a national backlog of more than \$878 million in delayed payments for veterans' emergency medical services delivered by non-VA providers.

Even though our hospital has not been paid by VA for services going back 4 years, we continue to provide care for the veterans in our communities we serve. However, continued lack of prompt payment and further reductions in Medicare and Medicaid reimburse-

ment would force our hospital and many other hospitals across this country to reduce or eliminate services offered to patients, resulting in reduced access to care for the entire community.

To help address this problem of prompt pay, the American Hospital Association recommends that VA do:

One, review claims as soon as practicable and, after receipt, determine whether they are proper. When a claim is determined to be improper, the Department should return the claim to the hospital as soon as practicable but no later than 7 days after the initial receipt. VA also should specify the reasons why the claim was improper and request a corrected claim.

Two, pay claims within 30 days of the receipt of a proper claim.

Three, make interest payments to hospitals when claims are paid outside of this 30-day window.

And, four, Congress should require VA to develop a metric to measure effectiveness of the claims processing, including soliciting feedback from non-VA providers. VA also should report to Congress on a regular basis the information it obtains from the effectiveness of this claims processing.

In conclusion, VA health system does extraordinary work under very difficult circumstances for a growing and complex population of patients. While the system is working to overcome operational changes, America's hospitals are eager to assist the Department and the veterans in any way that we can. The AHA stands ready to work with the committee to ensure prompt payment to non-VA providers so that hospitals can continue to provide vital services to veterans and all of the patients in the communities that they serve.

Thank you, sir.

[THE PREPARED STATEMENT OF VINCE LEIST APPEARS IN THE APPENDIX]

Dr. BENISHEK. Thank you, Mr. Leist.

Mr. Cook, you may begin.

STATEMENT OF SAM COOK

Mr. COOK. Good morning. My name is Sam Cook. I am president of Superior Van & Mobility. I operate nine mobility dealerships in four States: Kentucky, Indiana, Tennessee, and Louisiana.

I am president of and am here on behalf of the National Mobility Equipment Dealers Association. NMEDA is a nonprofit trade association which includes more than 300 highly qualified mobility dealers representing the small-business community. We specialize in modifying, selling, servicing specially equipped vehicles so that people with physical disabilities can drive safely and be transported on public roads in accordance with Federal motor vehicle safety standards. I would first like to say the NMEDA members are proud and honored to serve American veterans, especially those with disabilities, who have sacrificed so much for our country.

I want to thank the chairman and the committee for focusing their attention on VA slow-payment issue.

However, this investigation should not come as a surprise to VA. Over the past 5 years, NMEDA has attempted to work with VA prosthetics department and the Veterans Benefit Administration to help remedy these chronic slow-payment practices of local VAs. Over that time, NMEDA has submitted nearly 4,000 past-due in-

voices, totaling over \$34 million. To be fair, VA at times has assisted in getting past-due invoices paid, but after 5 years the situation has not improved.

According to the Prompt Payment Act, a payment is due 30 days after a government agency receives a proper invoice. This simply is not happening in most VA facilities. For example, a mobility dealer in North Carolina was owed \$247,000 from just one VA facility that included 15 separate invoices, all past due for an average of 150 days. A mobility dealer in Texas was owed \$295,000 from one VA facility that included 55 separate invoices, all past due an average of 312 days. At one point, my own company was owed a total of \$645,000 from five different VA facilities over four States, 68 invoices, all past due an average of 396 days.

These are just a few examples. This is completely unacceptable. Mobility dealers are small-business owners, and they simply cannot afford to carry this kind of debt on their books and pay suppliers and meet payroll.

It also bears mentioning that, in most cases, mobility dealers are not paid interest on these past-due invoices.

There are other payment process inconsistencies related to how a dealer submits proper invoices to even qualify for payment.

Finally, another VA inconsistency is VA has no criteria for selecting automotive mobility dealers. Anyone can claim to be a modifier without any training, appropriate facilities, equipment, or accreditation and then bill the government.

The lack of any meaningful or timely effort by VA to address slow payment, lack of conformity, and payment submission policy, and having no measurable selection criteria leads to a potential outcome of unsafe vehicles driven by disabled vets, placing them, their families, and the driving public at risk.

Based on NMEDA input, NMEDA has concluded that the reason for VA not being responsive to this constant outcry is multifold: number one, failure to communicate VA policy to the field; number two, inconsistent enforcement of the policy; number three, understaffing at VA; and, number four, supplier payment not being a VA priority.

Those of us that deal with different VA facilities have to deal with a different interpretation of the rules and policies at each one. As the saying goes, if you have been to one VA, you have been to one VA.

For the record, there is also evidence that this issue may be worse than either reported or imagined due to reluctance to speak out against VA in fear of losing future business. To be clear, there are no written or verbal threats; the local VA just stops calling or awarding business.

While \$34 million may not seem like a lot in terms of Federal budgeting, it is a huge amount to small-business owners who have to bankroll VA's inability to manage the payment process. We admit that not all VA facilities are guilty of slow payment, and dealers appreciate those who pay promptly, but our experience is the majority foster a culture of inconsistent, unenforced, or ignored policy.

We respectfully ask Congress to demand VA ensure that quality goods and services be delivered to our veterans and those busi-

nesses delivering those be paid in a timely manner. We all know our veterans deserve better.

Thank you. I would be glad to answer any questions.

[THE PREPARED STATEMENT OF SAM COOK APPEARS IN THE APPENDIX]

Dr. BENISHEK. Thank you, Mr. Cook. Thirty-four million dollars sounds like a lot of money to me.

Dr. MIGLIACCIO [continuing]. Is that how you say it?

Dr. Migliaccio "Migliaccio."

Dr. BENISHEK. "Migliaccio."

Dr. MIGLIACCIO. Yes, sir.

Dr. BENISHEK. All right. Doctor, you have 5 minutes. Thank you.

STATEMENT OF GENE MIGLIACCIO, DR.P.H.

Dr. MIGLIACCIO. Good morning, Chairman Benishek, Ranking Member Brownley, and members of the subcommittee. Thank you for the opportunity to discuss VA's reimbursement efforts for non-VA care providers.

I am accompanied today by Mr. Joseph Enderle, Director of Purchased Care Operations.

There are three important points I want to share with the committee this morning: First, we own the problem of aged claims. Second, we are fixing the problem. And, third, we will lean forward with continuous improvement and accountability.

VA's community care programs provide high-quality and accessible care to veterans. To ensure that care is available, VA understands the importance of complying with requirements of the Prompt Pay Act and making timely payments to our partners.

Section 106 of the Veterans Choice Act required the Department to transfer authority to pay for health care furnished through VA community providers and the associated budget to the Chief Business Office for Purchased Care no later than October 1, 2014. VA met this target.

In just 7 weeks, we quickly realigned about 2,000 positions, of which 50 percent of those positions are veterans, to the Purchased Care Office from the VISNs and our medical centers. This realignment established a single, unified shared-service organization responsible for payment functions and centralized management, allowing us to leverage business process efficiencies going forward.

VA has experienced tremendous growth in the volume of claims from community providers since we started the Accelerated Care Initiative in May of 2014. VHA has received 34 percent more claims from January 2015 through April 2015 compared to the same timeframe in 2014. We are making every effort to ensure claims are processed timely. Our current standard is to have at least 80 percent of our claims inventory under 30 days old.

Processing timeliness is measured from the point the claim is received to when the claim is processed and, as a result, marked as complete. As of May 22, 2015, our nationwide performance was 73 percent. And if our metric was aligned with Medicare processing standards for other than claims with no impropriety, which is about 45 days, our performance would be 76 percent. As of today, we are processing clean claims within 22 days.

Claims received by VA without prior authorization is one significant factor in the delay of claims processing. When claims without an authorization are received from community providers, our staff spends time to ensure those claims are adjudicated based on the veterans' eligibility. Based on regulatory and statutory authority, not all veterans are eligible for community care in all situations. When claims are denied, veterans are notified timely, along with the right to appeal.

I want to describe what we are doing to better our payment processes.

First, we are refining standard processes and performance targets and monitoring to ensure processing activities are performed and measured consistently across VA.

Second, to better process claims, we established the Support Claims Processing Division in March of 2015. This division was established to assist with processing claims when sites have high turnover, we see a sudden increase in claims, or need assistance with verification of claims. To address the increasing inventory, more staff was recently added to the division.

Third, the Chief Business Office established a contract to add support staff to process claims at those sites with significant inventories. Currently, 145 full-time employees and contractors are on board at Support Claims Processing Division. Over 40 more employees are expected to be onboard this month. VHA also plans to hire up to an additional 220 full-time employees.

Fourth, VHA is implementing technical fixes for issues preventing claims from being processed in a timely manner. All community care referrals require authorization. Without the authorization, claims cannot be processed, delaying payment. In some cases, authorizations are not entered timely in VA payment system due to administrative process. This is a processing issue we must resolve. We are working with non-VA care coordination staff to ensure authorizations are entered before a claim is received.

Finally, we are working with VA Center for Applied Systems Engineering to standardize business processing to increase efficiencies and reduce variation using Lean methodology. We have also completed technical site visits to evaluate how the current software design is meeting business needs.

We are finding better and more frequent ways to communicate the status of claims processing timeliness with stakeholders. Ongoing training is also being provided to community providers on the resources available to address their information needs.

Our recent actions have had a significant impact on processing volume. From January to May of 2015, VHA processed almost 6 million claims, a 21-percent increase from the roughly 5 million claims processed January to May of 2014.

We are thankful for the work of our community providers and their work in providing timely, high-quality care to fellow veterans, and we thank you for that. We are working hard to expedite payments and streamline our claims services in order to make this an effective and efficient system for all.

Mr. Chairman, I appreciate the opportunity to appear before you today. We are prepared to answer any questions you or other members of the committee may have. Thank you very much.

[THE PREPARED STATEMENT OF GENE MIGLIACCIO APPEARS IN THE APPENDIX]

Dr. BENISHEK. Thank you, Dr. Migliaccio.

I yield myself 5 minutes for questions.

Dr. Migliaccio, how long have you been on the job there at VA doing this job?

Dr. MIGLIACCIO. Sir, this is my fourth week.

Dr. BENISHEK. Yes.

This is not the first time that we have been at a hearing where we several people have testified about how things are, you know, in their perspective, and then we have had a VA person come and give us a litany of all the great things that VA is doing to improve the situation.

The fact that you make that statement and the fact that what is going on with these folks over here is still going on, it doesn't really jibe very well. Do you understand what I am saying?

Dr. MIGLIACCIO. Yes, sir.

Dr. BENISHEK. I hate to beat you up because you have just been here for 4 weeks, right?

Let me just list a couple of the things here that distress me, one of the things you said was, "we don't have a documentation for the claim sometimes due to the administrative process." That was one of the things you just said. The administrative process is a lot of the problem, Doctor.

One of the things that Mr. Montes mentioned was the 768 claims where they sent the documentation to VA. They have a certified mail receipts that it was signed for by VA. And yet VA doesn't seem to have the documentation necessary to pay the claim, despite the fact that it was signed before by a VA employee.

So what happened to those records? What is the story there? You should have those claims. Somebody signed for it. Where are they? Who is looking at them? Is it secure? You apparently don't know, as far as I can tell.

Can you answer that question for me?

Dr. MIGLIACCIO. Well, I thank you for the question.

I also thank the members of the committee and also Congress for the Choice Act because it has allowed us to standardize our processes and centralize.

And so, with questions such as where are the records, it is difficult to answer that question. I can ask my colleague, Joe Enderle, to answer. But when we are looking at the 150-plus medical centers and CBOCs that we have—

Dr. BENISHEK. Well, let's ask Mr. Enderle. Maybe he has a better idea.

Dr. MIGLIACCIO. Okay.

Dr. BENISHEK. What is the story there?

Mr. ENDERLE. Thank you, sir.

We do recognize that we have some internal process issues. Claims come in, paper claims come in EDI. And most of the time, especially with inpatient claims, unauthorized claims, and Mill Bill claims, we must have the clinical documentation to adjudicate those claims.

Dr. BENISHEK. Yes, we know that. But you apparently have them; you just don't know where they are. Where are they?

Mr. ENDERLE. Actually, when the clinical documentation comes in, we scan those claims into our Fee-Basis Claim System. Sometimes those claims are delivered directly to our file room. Those claims are subsequently again scanned in our VistA Imaging System.

We acknowledge that we have had difficulty in pockets of the country where the processes aren't, you might say, functioning seamlessly and timely. So we are addressing—

Dr. BENISHEK. 768 claims is a lot of claims. It is thousands of dollars, I am sure, for these folks here.

I guess what I need and the problem that I always get with this is, can I have you be the one responsible for coming up with an answer of why these claims are gone? Who is going to take responsibility?

The problem I have with VA is it is never anybody's fault. There is nobody actually responsible, so—

Dr. MIGLIACCIO. I will take responsibility.

Dr. BENISHEK. Well, then, what that means is that I want an answer to this 768-claim business. The administrative processes answer doesn't really wash very well.

Dr. MIGLIACCIO. Yes, sir. We will work with our community providers. If we can get the data, the details, we can start doing the research.

Dr. BENISHEK. Well, I will expect an answer to that question within a month then.

Now, the other question I have is, what do you think of this idea of having a third-party person do the claims thing? It seems like Medicare or Blue Cross does a much better job, adjudicating these claims, millions and millions of claims at a time. What do you think of VA contracting that service out?

Dr. MIGLIACCIO. It is something to think about. We would certainly take a look at—we could do a cost-benefit analysis to see where it makes sense.

Dr. BENISHEK. Yes, okay. All right. Appreciate that.

Mr. Montes, do you think that would be a viable offer for VA, to have them contract that claims processing out to somebody that actually does it for a living?

Mr. MONTES. Absolutely. I mean, we do it for the TRICARE claims through Humana, so some of our Active Duty, their claims are processed through a fiscal intermediary. So the precedent has really already been set.

Dr. BENISHEK. All right. So there is an idea.

I will yield now to Ms. Brownley. Thank you.

Ms. BROWNLEY. Thank you, Mr. Chairman.

Mr. Cook, I had a question for you. You mentioned VA inconsistency and the lack of criteria for selecting mobility dealers in your testimony. Can you elaborate a little bit more and explain what you mean by this?

Mr. COOK. Sure.

You know, right now, you and I could open a mobility business and register with the government. We just send our paperwork in, nobody looks at us, and we are a mobility dealer and we can do business with VA.

And the handbook that VA is going off of, which I have in my hand, on the first page is dated October 30 of 2000. That is October 30 of 2000. Several different administrations of both parties have been through, so it is not an issue there. Supposed to be updated by 2005.

And we have met with VA, and because technology has changed in our industry, the nature of it, from being high-tech vehicles that are being produced now, there have to be some standards, so to know that the person has insurance, to know that the person has 24-hour service, to know that the person providing has facilities that are even ADA-compliant. And these are things that VA does not ask for.

And we have gone to VA and they say that is a good idea, but we are still here.

Ms. BROWNLEY. So you have gone to VA; they have said it is a good idea. But we are now in 2015. We are operating under 2000 standards that were supposed to be—or at least the handbook—updated by 2005?

Mr. COOK. Correct. And when each year we go and we meet with them, they say, “Well, we are working on it. It will be the next year. We will have you something.” And it has just been, you know, a slow process. It is supposedly in the regulatory process at this point now.

But, again, veterans are still being—have the potential to have unsafe vehicles out there that it not only affects the veteran, it affects all of us on the road. When you take a vehicle and you put a 300-pound wheelchair and a 200-pound lift on the back of a Toyota Prius, which happens, the vehicle’s rear end goes way down and the front end goes way up. We have all seen it at our local grocery stores. And that is an unsafe practice.

Ms. BROWNLEY. So you could provide some evidence of dealers out there that are not modifying automobiles correctly for the veteran that could be quite dangerous for them rather than assisting them?

Mr. COOK. Yes, ma’am.

Ms. BROWNLEY. Thank you.

And, Mr. Migliaccio, are you aware of this issue, that it has been 15 years and VA still hasn’t updated the handbook?

Dr. MIGLIACCIO. I am not aware of the issue about the handbook, but I am aware of the issue in terms of the durable medical equipment that VA purchases.

Veterans Benefit Administration takes care of service-connected veterans, and I believe Mr. Cook alluded to that in his testimony. The non-service-connected veterans are handled by the VHA through our prosthetics program.

We know that Mr. Cook and his team met with our staff at VHA about 3 weeks ago. We know there are no outstanding claims from the VHA side. We also know that, from a quality standpoint, in terms of the request for VA to endorse one association over another is something that many Federal agencies just aren’t in—it is not in our wheelhouse to do. So what I can say is that I understand the issues that Mr. Cook has, but within the VHA side and with our Business Office it is a little out of our wheelhouse. But we can certainly work with Mr. Cook.

Ms. BROWNLEY. Thank you.

And, Mr. Cook, do you agree that there are no outstanding claims?

Mr. COOK. No, ma'am. There are—I have three right here of my own company. 9/25 of 2014 for \$25,600. I have—there are millions of dollars right now that are past due nationwide. That is bizarre, to hear somebody say that there are not VA claims out there right now.

Right now, the issue—the VBA goes through the prosthetics to handle the service-connected veteran. They administer the program. The service-connected vet is being taken care of by the prosthetics department, which then sends the bill back to the VBA for processing. So you have two different hands on the program, which makes it very confusing.

So the prosthetics department approves it, sees it out, and then it goes back to the VBA for payment. So they are always pointing fingers at each other, saying, well, no, it is their fault; no, it is their fault, we have sent it in. The mobility dealer sends the invoice to the prosthetics department. They sign off on it, then send it to the VBA regional office for payment.

Ms. BROWNLEY. Thank you very much.

My time is over, and I yield back.

Dr. BENISHEK. Dr. Huelskamp.

Dr. HUELSKAMP. Thank you, Mr. Chairman. I appreciate the topic of this hearing.

I have heard consistently concerns about a lack of prompt payment. I would like to ask the doctor from VA, can you describe how the Prompt Payment Act applies to VA and how quickly you are required under that act to make payments?

Dr. MIGLIACCIO. Yes, sir.

The Prompt Payment Act from 1982 states that Federal agencies have an obligation to pay timely, within 30 days, and there is a privity of contract between a Federal agency and a provider.

In our case, we do pay interest on late claims. We pay those—

Dr. HUELSKAMP. Could you provide for the committee how much interest you paid on these claims in the last fiscal year?

Dr. MIGLIACCIO. Last year, close to \$200,000.

Dr. HUELSKAMP. What is the interest rate you pay?

Dr. MIGLIACCIO. Well, I would have to get back to you on that.

Dr. HUELSKAMP. Okay.

All right. What is the application of—or what is your expectation for prompt payment for those that are not payments that would not be covered under the Prompt Payment Act, noncontracted providers, which is where I hear those complaints at? How quickly do those get paid?

Dr. MIGLIACCIO. Well, as I mentioned in testimony, we pay our claims right now within 22 days, clean claims. Claims that are pending, we—

Dr. HUELSKAMP. Twenty-two days of receipt of the claim or processing of the claim, scanning of the claim? What is the start of the claim with your statement?

Dr. MIGLIACCIO. As soon as it is scanned into the system.

Dr. HUELSKAMP. Okay. Well, that is a good point.

I am looking here at a copy of a status report, or a response to a request for a status update from one VA facility. And they said, "Please be aware"—it is of January 1, 2015—"there is a scanning backlog of approximately 90 to 120 days."

So, based on your statement, then, your definition, 22 days is after 120 days, perhaps, before the claim is even scanned in, and then the 22 days? Am I understanding that correctly?

Mr. ENDERLE. If I may address that, sir, we did check into that issue. The large backlog with scanning that you are referencing is actually scanning of clinical documentation. It is not associated with scanning the claims. The claims are——

Dr. HUELSKAMP. Certainly you don't process the claim without documentation.

Mr. ENDERLE. The claims, if they are preapproved, authorized claims, outpatient services, we do not require the clinical documentation to process those claims for payment. So the outpatient, preauthorized claims, as long as it meets the authorization requirements, it is in our system. We process those claims. And those typically, as has been mentioned, are processed within 22 days.

Dr. HUELSKAMP. So why would you send a provider—this is basically an excuse of why they have been waiting months to be paid. And, again, told them 90 to 120 days before you even start the claim. Is this because they are a noncontracted provider? Or what is the distinction between those two as far as you handle them?

Mr. ENDERLE. Sir, we process the claims the same, whether it is contract or noncontract. They come in electronically, they come in paper, they are scanned.

If the claims require clinical review and clinical documentation, that clinical documentation has to be scanned so that we can review it. We acknowledge that there is a backlog in scanning that clinical documentation. And you are absolutely right; it does impact the processing of those claims associated with the requirement of clinical documentation review. So we have——

Dr. HUELSKAMP. I am a little confused, Mr. Chairman.

If you are not looking at documentation except in certain circumstances—so you are paying claims without documentation, even though we are hearing here you aren't paying many claims on time at all—but you are saying—what percentage of claims do you pay with absolutely no documentation? You are scanning the documentation months after you pay the claim; is that what you are telling the committee?

Mr. ENDERLE. At that one particular location, there is a backlog in scanning that clinical documentation.

Dr. HUELSKAMP. So they paid thousands of claims with no documentation?

Mr. ENDERLE. Outpatient, preauthorized services are paid without clinical documentation, that is correct. The only requirement of clinical documentation are for those claims that are——

Dr. HUELSKAMP. Why are you scanning them in 3 months later, 4 months later, if you have already paid the claim? That is your claim for the committee.

Mr. ENDERLE. Specific claims that require clinical documentation are inpatient claims, emergency outpatient claims, emergency inpatient claims. We require the clinical documentation to adjudicate

the point of stability, if an emergency existed, and the length of stay that the veteran is in that particular hospital.

Dr. HUELSKAMP. Well, your statement doesn't match with what VA facility was saying.

And I will enter this in for the record for the committee.

Dr. HUELSKAMP. But, also, the entity was told to wait 60 days to even call in. I mean, is this actually occurring, that you are saying, "Well, don't even call us for 60 days"? Or when you call in—another example—when you call in, "We will only let you discuss four claims on the same call, and then we have to hang up on you." Is that actually occurring?

Mr. ENDERLE. That was occurring, sir. We acknowledge that, as we took over, with the implementation of the VACA law, we did go out to the sites, we met with sites, we did find situations like this. When we discovered these situations, we immediately stopped it.

In this particular case, we did reach out to the site. We instructed the site that they are not to issue that document you are referencing again. And we implemented processes to ensure that when callers call in that they can resolve any issues of the claims that they have on hand.

Dr. HUELSKAMP. I yield back, Mr. Chairman.

Dr. BENISHEK. Thank you, Mr. Huelskamp.

Mr. Takano.

Mr. TAKANO. Thank you, Mr. Chairman.

My first question for the panel, for anyone who wishes to answer it: The Choice Act has led to a lot of rapid change at VA, and I understand that claims for non-VA care have increased by 34 percent over this time last year, and VA has consolidated claims processing under the Chief Business Office.

Has the late payment situation improved since the Choice program has been instituted?

I guess, Dr. Migliaccio, you might want to answer that question.

Dr. MIGLIACCIO. I will start.

It has improved. We have brought together—when you centralize anything, it is going to take some time. And that process is behind us now, and what we are starting to see is some phenomenal traction, especially when you look at that we are processing clean claims within 22 days. And that—we are following the standards in the industry.

Mr. TAKANO. And a clean claim is a prior-authorized claim?

Dr. MIGLIACCIO. Yes, sir.

Mr. TAKANO. Now, my colleague Mr. Huelskamp was asking a line of questions about the scanning that goes on with the medical documentation afterwards. Am I correct in—my understanding is, from listening to you, Mr. Enderle, that that scanning of claims or the documentation afterwards is for the non-clean claims. Is that right, or am I wrong?

Mr. ENDERLE. Anytime that we receive claims associated with inpatient stays, emergency admissions to emergency rooms or emergency admissions, we require clinical documentations.

In addition, if we receive a claim that has not been previously authorized, which is considered an unauthorized claim or a Millennium Health Care Act claim, in that scenario, we require the clin-

ical documentation so that we can adjudicate the claim and determine if we can pay the claim on behalf of the veteran.

Mr. TAKANO. So for those first types of claims that you described earlier, those could be preauthorized. It is just that the inpatient hospital stays are of a different nature, and do you have to get the documentation, the medical documentation for that?

Mr. ENDERLE. Yes, sir. They could be preauthorized, and that is what we of course encourage, is that when a veteran shows up at a non-VA facility, if they have an emergency, we encourage that non-VA facility to contact the closest VA so that we can preauthorize that claim.

Mr. TAKANO. I mean, so the nonpreauthorized claims and these other types of claims you mentioned, how much of the delay is due to medical records being inoperable? I mean, you are dealing with a lot of non-VA providers who have different—I am assuming that all these records are coming in paper; that is why you have to scan them. Is that right?

Mr. ENDERLE. That is correct. We try to work with the providers to provide them information on the best way to send those claims in.

Mr. TAKANO. And, as I recall, some of the hesitancy of VA, when we were talking about moving toward non-VA care to address the backlog, was this concern about the interoperability of medical records with non-VA providers. I mean, that is what I recall.

Is it reasonable to say that this is a significant part of the problem in terms of paying late claims?

Mr. ENDERLE. Yes, sir, I agree. If we can receive the clinical documentation with the claim, we can expedite the processing of that claim.

We also have a couple initiatives we are working on with working with providers themselves to turn that into an electronic access so we can access their system, pull down those clinical documents, so we do not have to mail the claims back and forth.

Mr. TAKANO. Mr. Leist, you mentioned this issue of lost medical records. And it is lost paper records mainly; isn't that right?

Mr. LEIST. Yes, sir. Thank you for the question.

Yes, it is lost paper records. But I have to reiterate that, when we send records to VA for processing, they are sent certified mail. So we know those records arrived. We are being told——

Mr. TAKANO. I don't think the problem is that the—I mean, I think the problem is also in the manpower or the personnel it takes to scan those records. So they may receive them, but it sounds like the volume of medical records is also the issue.

Is that true, Mr. Enderle?

Mr. ENDERLE. That is correct. And in the particular location that Mr. Leist is referring to, we did identify significant issues at that location both with vacancies and the internal processes that they utilize to acknowledge and scan those documents. There was——

Mr. TAKANO. So you could see there were some significant administrative snafus at that particular site?

Mr. ENDERLE. At that particular site, that is correct. It is not a problem that we experience——

Mr. TAKANO. Mr. Leist, do you have something more to add?

Mr. LEIST. Mr. Takano, I appreciate the comment. We would—I will speak for my hospital. Hopefully the other hospitals that are represented by the American Hospital Association would say the same thing. We would welcome electronic transmission of records to VA. We would be very interested —

Mr. TAKANO. I am very interested in trying to facilitate that. And if we can get the funding—I don't recall if we ever inserted that into the Choice Act. But that is a high priority of my office, is to facilitate—I think non-VA care would be highly facilitated between—if we were to get this interoperability to work with all those providers.

Dr. BENISHEK. Thank you.

Dr. Wenstrup, you are recognized.

Dr. WENSTRUP. Thank you, Mr. Chairman. I appreciate it.

Dr. Migliaccio, one question I have is, where is your predecessor now? Still working within VA?

Dr. MIGLIACCIO. No. I believe she retired, sir.

Dr. WENSTRUP. Okay. Because there has been a pattern here that we get new people when there have been issues that have been difficult. And so I am wondering if there is a reason for that, that you get somewhat thrown to the wolves in this situation, but we get somebody that has only been there 4 weeks to have to answer all these questions. It makes it difficult for us and certainly for you, as well. But it is a pattern that we have seen.

My next question is going to claims that were submitted and signed for and what is the process for tracking down the person that signed for that claim that came in and trying to find that claim. Because they get a card back that tells them who signed it. So do you have a process in place of trying to track down the person that signed for the claim that seems to be missing?

Mr. ENDERLE. The claims are typically received in the main mailroom at the facility. When those claims do come in at the mailroom, that is typically when those are signed by certified mail.

They are subsequently then delivered to the non-VA care payment office, where they are scanned into our doc manager system. Or if the mailroom for whatever reason believes those medical records should be sent directly to the medical record file room, they may be scanned into what we call VistA Imaging.

So we have identified an internal problem with that process, and we are attempting to fix that issue.

Dr. WENSTRUP. Yes, I would suggest that the person at the mailroom that signed for that gets a signature for who they turned it over to so there is some level of responsibility here, rather than blaming a computer glitch or a scanner that didn't work. Then you might be able to actually track these claims. And that is a large number of claims that were signed for and lost.

My last question is to you again, Doctor. Would you be in favor of accepting bids right now from an outside source to process their claims?

You talk about increasing the technology to do electronic claims. There are a lot of people that are already doing it and doing it successfully. And these gentlemen will tell you that, because they submit those claims and they get their payment.

So will you take the lead for us on getting some bids? That shouldn't cost us anything. And maybe we can start to begin to assess whether this would be a good business move for everyone involved.

Dr. MIGLIACCIO. We currently have a request for information on the street right now to look at a new system.

In terms of contracting out the entire process, we could certainly do the cost-benefit analysis and see what makes sense.

Dr. WENSTRUP. Well, I think that would be part of it. You know, you talk about the cost of a new system. How about the cost of outsourcing it and actually getting the job done? I think that is a component that we need to look at if we are going to make a good, wise business decision that helps not only our providers but our patients.

So I would hope that at our next meeting we have some of those numbers that maybe some of the outside sources give us a bid on that. And I would appreciate that.

Dr. MIGLIACCIO. Thank you, sir.

Dr. WENSTRUP. Thank you.

And I yield back.

Dr. BENISHEK. Thank you.

Ms. Kuster, you are recognized.

Ms. KUSTER. Thank you, Chairman Benishek.

And thank you to all of you for providing services to our veterans. We are grateful for that.

I think I want to follow up on the line of questioning my colleague Mr. Takano started. But, also, just to comment on this approach of a third-party vendor, I am not opposed to that; I just don't know that that is going to solve the problem unless we solve the issue of the electronic records.

And I think where this seems to be headed is that the backlog—it is not a question of who signs for it in the mailroom. It is a question of you are ending up with boxes and boxes and boxes of medical records that aren't getting into the system in a timely way.

So I want to follow up on that issue of electronic records. And if I could start with you, Mr. Leist, in the private sector, when you are dealing with a claims processing, how do you transfer the records? And just walk us through what that process looks like. I am going to assume it is not reams of paper records.

Mr. LEIST. Thank you for the question.

First, I would like to comment a little bit on the entire process of submitting a claim. I have found, as I have compared the preauthorization process for patients with VA system and according to the commercial processes, VA system is extremely cumbersome. And, often, as reported in a recent document that was submitted to this committee, it requires the signature of a department head in the area where this particular procedure would be performed.

Also, there are many issues I would like to address with the Veterans Choice Program.

But, to answer your question, we submit claims electronically to many commercial providers. They pay us in a timely manner. If there are claims that are not supported by documentation, we can address those immediately and resubmit those documents. The

communication between our hospital and commercial providers is open, it is active. We are not limited to the number of cases we can address over a phone call. Their claims processing people are available to us, which has heretofore been very different with VA system.

Ms. KUSTER. Well, I think we have an opportunity here. We have a Secretary that comes from the private sector. He is looking to make these kinds of changes.

And I think we can find bipartisan support to get us to the place where we can meet that standard. And it sounds to me, from the testimony from our VA representatives, that on the preauthorized claims we are getting close to that commercial standard, that the complication here is on the other types of claims—emergency room, inpatient, et cetera.

So I will cut my questions short, because I just would like to work with you all going forward to get us to this commercial standard. I think this is reminiscent—I am in my second term, but when we first got here and started having hearings about literally warehouses collapsing under the weight of paper records that were being kept in boxes Lord knows where—and I think what we have to do is try to get VA to the 21st century. And this is a clearly a place where there is room for improvement.

I would like to work with VA and with my colleagues on the other side of the aisle to get us to that commercial standard so that, number one, our veterans are served best and foremost; number two, our small businesses are paid in a timely way to be vendors to our government and to our veterans; and, number three, the taxpayers are served. Because this particular system doesn't seem to be working for any of those three.

So thank you for your patience, and we will look to work with VA to move forward on this.

Thank you, Mr. Chair.

Dr. BENISHEK. Thank you, Ms. Kuster.

Mr. Coffman.

Mr. COFFMAN. Thank you, Mr. Chairman.

Well, there is just a pattern here where I bet you 3 years from now we will be holding the same hearing with the same results, and the only difference is there will be a new director who will have been there for 4 weeks. He will be here, and he will be telling the same thing that you are telling us.

And when you have a culture that is so inbred where bad people can't be fired, where the good people that fundamentally care about serving our Nation's veterans become whistleblowers and they are retaliated against by the system, and the only people that come before this committee to represent the Veterans Administration are the get-along, go-along folks that are just good at answering questions but they are not good at doing anything—and so, you know, there is one solution here, and that is to outsource it by the people that professionally do this.

I am a retired military person. I am in TRICARE. And TRICARE uses third-party payers that efficiently, you know, reimburse providers. And so it is not being done by VA, and I can't imagine that it will be done, but we will make changes on the margins, I hope, and, I guess, that is considered progress here in Washington, DC

So, Mr. Migliaccio, there is a company in my district, AMR, American Medical Response, and I think they were owed \$10 million. Now the number is up to \$12 million over 90 days. I understand you are having—at least there are phone conferences with them on a routine basis. But what plan would you suggest to provide AMR with some resolution to their backlog of claims at VA?

Dr. MIGLIACCIO. Thanks for the question.

Sir, for the record, I wanted to state also, I am a retired uniformed officer, too, Air Force and Public Health Service, so I get TRICARE also.

And we will take a look at this, but I have to tell you—

Mr. COFFMAN. Well, we are both lucky.

Dr. MIGLIACCIO [continuing]. We are going to get this done. That is why I came here. I came from Health and Human Services. So I chose this path to be here to make a difference.

Mr. COFFMAN. Well, I hope so.

Dr. MIGLIACCIO. Yes, sir. But we have been having conversations with AMR, and I am going to let Joe handle it because he's been closer to it and also done some visits on site.

Mr. ENDERLE. Thank you for the question.

In response to the question, the ambulance reimbursement process is very complicated. It also falls under different authorities and regulations. We authorize ambulance transports, which falls under Beneficiary Travel. And the ambulance transports that are taken care of in Purchased Care are those transports that are associated with unauthorized and Millennium Health Care Act claims. Because of that, we have to meet the regulatory requirements. We review those claims, we review the clinical documentation, and then we must make a determination whether we can pay those ambulance claims.

Believe me, we would like to pay all the ambulance claims for all veterans, because we do appreciate the fact that they are transporting our veterans and taking care of them. But, as mentioned earlier in the testimony, not all veterans meet all the eligibility requirements, and in order to make that determination, we have to do a clinical and administrative review.

Many of the veterans are not eligible under unauthorized claims or service-connected veterans or non-service-connected to veterans who have no means to pay. But we take extra steps to ensure that those veterans' claims are reviewed thoroughly to make sure that if they do meet all the eligibility and regulatory requirements that we can pay those claims on their behalf.

Mr. COFFMAN. Yes. And how can this problem be resolved so that the claims for veterans' ambulance service are not held hostage, waiting for records that are completely outside the control of ambulance service personnel?

Mr. ENDERLE. We recently reviewed the processes associated with unauthorized and Millennium Health Care Act claims. Staff in the field have been informed that they could use the ambulance report. If they can determine it meets, you know, the stipulation that it was an emergency for a layman's interpretation and the clinical documentation on the ambulance report is sufficient, we are not requiring the facility clinical documentation to adjudicate those claims. So we have made a change in that process.

Mr. COFFMAN. And, Mr. Montes, what type of excuses other than the ones that you discuss in your testimony are commonly heard from VISNs when they are asked about past-due ambulance claims? And, with your work directly with VA, have they given you any idea or ideas on how they plan to resolve them?

Mr. MONTES. So there is a twofold issue.

One is those transports that are done under contract with VA, so they are more authorized. And when you are actually speaking—usually there is just one individual at that local facility that is doing them. So if something happens or they go on FMLA, a lot of times the processing just stops until they come back.

If it is unauthorized or it is going through the Fee Basis unit for payment, we have heard every excuse. There is not enough time, or there are too many claims; we don't have enough people to process those claims. They don't call you back. They are taking a lot of effort to try to allow you to do more than four claims to check, but it is just—it is an insurmountable—or it is the wrong VA, you need to send it to another VA, this VA doesn't provide 911 service.

So the emergency benefit of it is one issue. The nonemergent or the transports that are actually originating out of VA facility is typically under authorized care, and that is a different issue in itself.

Mr. COFFMAN. Thank you, Mr. Chairman. I yield back.

Dr. BENISHEK. Thank you, Mr. Coffman.

Dr. Ruiz, you are recognized.

Dr. RUIZ. Thank you, Chairman Benishek and Ranking Member Brownley, for holding this hearing.

And thank you to the panelists for your participation.

Last Congress, I was proud to come together with committee members in both chambers to streamline VA's payment processing systems. As VA implements this centralized processing and payment system for all VA fee-basis care, we must ensure that the focus remain on the veterans, that inefficient reimbursement does not hamper veterans' access to services, make it harder for veterans to seek answers from VA, or expose veterans to financial harm. In this vein, VA must make certain that veterans are held harmless from any problems the agency has paying its bills, which are certainly no fault of our veterans.

A Vietnam veteran in my district, a good friend of mine, who has been approved to obtain 100-percent fee-basis care for more than a decade, still reports frequent delays in VA payments to his providers. When unpaid by VA, these bills go to collection agencies, which can damage the veteran's credit rating and expose the veteran to stressful harassment from collection agencies and to financial harm.

So, Mr. Migliaccio, in the interest of preventing veterans from enduring similar struggles, what safeguards are in place to prevent veterans from incurring financial harm, poor credit ratings because of delayed VA reimbursements to fee-basis care providers?

Dr. MIGLIACCIO. Thanks. I will start.

We want to put some systems in place so it doesn't get to where the veteran is harmed at all. So we want to start from the front end, and that is in terms of developing really a solid system. And I won't get into this now to take the time, but I am going to focus

on our people, and we are going to focus on business processes, and I want to look at technology, also, so we can prevent this from getting to our veterans.

Dr. RUIZ. Okay. So, in other words, you are going to prevent it by improving——

Dr. MIGLIACCIO. Yes, sir.

Mr. RUIZ [continuing]. Your reimbursements.

However, you have hundreds, if not hundreds of thousands, of veterans out there who already have poor credit ratings because of VA's fault and no fault of their own. So what are you going to do about them?

Dr. MIGLIACCIO. Well, I have looked at the issue, and I have looked at the information that we have provided back to your office. I don't know if it is—the extent of the issue is there. It is not as severe as we think because our relationship is really with the provider. And if a provider——

Dr. RUIZ. Time out, time out, time out.

Dr. MIGLIACCIO. Yes, sir.

Dr. RUIZ. When you say it is not as severe as you think, now, I know that you are thinking as an epidemiologist, and you are looking at the big picture, and it is systemic-wide. But for one veteran whose credit rating makes it a matter of whether he can pay rent or not, it is severe.

Dr. MIGLIACCIO. Yes, sir.

Dr. RUIZ. So, for those veterans, whether it is 1, 2, 10, 20, who are barely making ends meet, if you are not paying their bills and they are getting poor credit ratings, they could be evicted, and then you have just increased your homeless veteran problem, right? So what mechanisms can you do to remedy that poor credit rating?

Dr. MIGLIACCIO. Well, one veteran being affected is one too many. We have some situations in place right now. We will go on behalf and work with our veterans. If this situation arises, we will work with the providers that sent the bills so we can adjudicate those claims quickly and check that out. We also will write letters to credit agencies to clear up credit reports for our veterans——

Dr. RUIZ. Okay. So I would like you to commit to working with this one veteran so that we can use that as a case study and you can demonstrate what you can do not only for this veteran, for the other veterans.

The other issue that I want to touch on is that I am very concerned about what just transpired here. Mr. Cook said that there are millions, if not billions, of dollars left unpaid, and, prior to that, you had said that there are no outstanding claims. So there are some serious discrepancies between what Mr. Cook said and what you are saying.

So if you don't identify a problem, you are not even going to attempt to fix it. So if there are—and he can show you examples of late payments. So what are you going to commit to do to remedy and rectify this discrepancy?

Dr. MIGLIACCIO. Well, I will definitely work with Mr. Cook, and I will ask for the information that he has brought forward, and we will see how we can work.

I did my research with the Veterans Health Administration to ensure that there were no outstanding claims there. If there are,

I would like to take a look at them, because we are going to fix that.

Dr. RUIZ. Okay. I will follow up with you and with Mr. Cook to make sure that these different examples are handled in a timely fashion so that we can get an example and maybe build some trust with our new Administrator here that he can demonstrate to us that things may change.

So this is going to be a trust exercise between you and this committee.

Dr. MIGLIACCIO. Thank you.

Dr. RUIZ. Is that okay?

Dr. MIGLIACCIO. I am on.

Dr. RUIZ. Okay.

I yield back my time.

Dr. BENISHEK. Good. Nice job.

Dr. Abraham.

Dr. ABRAHAM. Thank you, Mr. Chairman.

Well, certainly, we have two gentlemen that do business in my State of Louisiana. And I appreciate the testimony of the three of you, because, as Dr. Benishek alluded to his opening statement, it takes moral courage to be here because of the retaliatory that VA may or may not do. So, again, I appreciate you three gentlemen being here.

Mr. Montes, you said that—and Mr. Leist—that you all had sent certified mail and they were signed for.

Mr. Enderle, you are telling me you are 120 days behind on scanning, which is fine, I guess, in a way. But the claims that Mr. Montes and Mr. Leist are talking about are far more than 120 days, so hopefully they have been scanned in. But Mr. Montes says that he checked today with his office and there is still no record of those 768 claims. So I suggest that maybe VA has a HIPAA compliance issue also here, because you are responsible now for those medical records.

I guess my question—Mr. Montes, let me ask you first. Based upon VA's written testimony, they indicate that many providers submit duplicate claims. Can you explain why this may be occurring?

Mr. MONTES. And this is from experience that we have regarding the duplicate claims.

There are a lot of times that you can actually submit—and some of the veterans' claims you can actually submit electronically, either through a clearinghouse—they let you know you can send through a clearinghouse, but they will need the medical records, so you will have to send a paper record along with it. So, in our opinion, when we are actually doing the audit and we see that there is a mass amount of duplicate claims that we are getting, that that probably has something to do with it.

The second thing is, especially with an authorized claim that we are under contract with VA, a lot of times they want us to send that via email to that contracting officer so they can first approve the claim before you submit it into their electronic system, which is the OB10 system. And then at that point in time is when the clock really starts.

So it is—I mean, just to kind of give you an update on that, there is a lot of that practice happening with the contracting officer at the local VA. When you are contracted, it is: Send us the claims first, let us review them to make sure everything is correct, then put them into the OB10 system. So then the clock actually starts at that point from the Prompt Pay Act provision.

So there is probably a dual thing going there, Congressman.

Dr. ABRAHAM. Okay.

And a quick followup to that, and I will get to Mr. Enderle.

You indicated, Mr. Montes, in your statement that your accounts receivables have doubled since 2014. Can you give me some numbers?

Mr. MONTES. Absolutely.

Probably about 2-1/2 years ago, when we actually started this process, we were at about \$1.2 million in aging receivables in 180 days. And we worked diligently with VA, with our local VISNs. We actually got it down the end of last year, around September, October, to about \$500,000 over 180 days. And we were doing high-fives and having champagne because that was exciting.

But ever since October, it has now doubled. We are back at about \$1.8 million now.

Dr. ABRAHAM. Thank you.

Mr. Enderle and Doctor, I will ask you these questions. You stated that the delay sometimes in processing is caused by the preauthorization process. Now, I have been on the doctor end of it, and I know that if a claim is not preauthorized it is usually not paid.

And what these gentlemen here are telling us is sometimes they are having to stay on the phone minutes, if not hours, just to get a preauthorization. And I can assure you, there are many, many times, probably the majority of the times, that you can't wait to get a preauthorization on a CT, MRI, or something of that nature but you have to take care of that patient.

Is preauthorization required for 911 claims?

Mr. Enderle, I will ask you that question.

Mr. ENDERLE. Thank you for the question, sir. Could you—I didn't hear the last part of your question.

Mr. ABRAHAM. Well, is preauthorization required for 911 claims?

Mr. ENDERLE. For 911 claims, where they call the emergency room, the veteran would—it depends. If there is a contract in place and the veteran meets the eligibility—

Dr. ABRAHAM. All right, let's get past that. But you are saying the answer is, then, at least some are needed to be preauthorized—

Mr. ENDERLE. Yes, sir.

Dr. ABRAHAM. Okay. Well, that negates the purpose of a 911 call to begin with. If you have to go through the preauthorization contract, to get on the phone, reach somebody that may or may not give you an answer, that you may wait 20 to 30 to an hour long, that negates the definition of "emergent."

Mr. ENDERLE. If we are talking about an inpatient stay, however, they do have 72 hours to contact the local VA facility.

Dr. ABRAHAM. Yes, but no inpatients are 911 calls. These are outpatients that are having a heart attack or a stroke or some issue like that.

I am out of time, Mr. Chairman. I yield back. Thank you.

Dr. BENISHEK. Thank you, Dr. Abraham.

Well, I still have one more question I want to ask. And I think, since we have one panel, if others would like to ask questions, then we will try to give people an opportunity to do that.

There are so many things that I want to get at. One thing here that came up in some written testimony. Apparently, AMR, American Medical Response, referenced \$12 million in backlogged ambulance claims. Mr. Boustany from Louisiana mentioned \$878 million in emergency care claims.

[THE PREPARED STATEMENT OF HON. CHARLES W. BOUSTANY APPEARS IN THE APPENDIX]

Dr. BENISHEK. And a statement for the record by AMR said, "We are often told that VISNs are out of funds appropriated for ambulance services in their budgets and we will have to wait until the next fiscal year to be paid for our claim." This can occur as early as the first quarter of the year.

Dr. Migliaccio or Mr. Enderle, how much money is currently available in VA's non-VA care fund?

Mr. ENDERLE. The specific—

Dr. BENISHEK. Some people are being told that there is no money in their budget to pay the ambulance; you will have to wait till next year.

Mr. ENDERLE. Actually, that is a great question.

Dr. BENISHEK. So I am trying to figure out what is the story with that?

Mr. ENDERLE. Yes, sir. Whenever a claim is authorized, the obligation for the funds to pay for that authorization is obligated up front. There should be funds available to pay those claims.

Dr. BENISHEK. So you don't have any idea how much money there is available in VA's non-VA care fund?

Mr. ENDERLE. It is substantial.

Dr. BENISHEK. Can you just get me that number in the next month?

Mr. ENDERLE. Yes, sir.

Dr. BENISHEK. All right. Thank you.

The other question I want to ask is that, Mr. Montes, there was this meeting, apparently, in August of 2014, where AMR—and VA officials addressed some of the backlog issues. You guys had a conversation about how things were going to get better, and we are going to work on things, and you made some recommendations and offers for collaboration and problem-solving.

Did anything happen after that meeting and collaboration? Did things improve? That is what the whole process we are trying to figure out today is, can VA learn from you guys and make things better. What has happened since then?

Mr. MONTES. So this was a collaboration with American Medical Response and Acadian Ambulance Service when we met in Atlanta, Georgia, with the national VA facilities as well as several representatives from the VISNs. It actually got probably a little better.

They started actually having phone calls. They were trying to research, try to figure what things happened.

But whenever VA Choice Act was implemented, things just started to break down at that point. And my colleagues at American Medical Response, even with their phone calls that they were having every other week, it just seemed it was the same information being given back to them.

Dr. BENISHEK. Rehashed.

Mr. MONTES. So it started off good. It started off as a partnership. And then it just kind of became one-sided at that point, because then there was just a lot of inaction.

Dr. BENISHEK. Right. Right. That is the problem we have.

Ms. BROWNLEY, do you have a question?

Ms. BROWNLEY. I do. Thank you, Mr. Chairman.

It was said earlier, I think by Mr. Migliaccio, that you have paid \$200,000 worth of late interest payments. Was that within the last year or within the last couple of years?

Dr. MIGLIACCIO. Last fiscal year.

Ms. BROWNLEY. This fiscal year?

Dr. MIGLIACCIO. This fiscal year.

Ms. BROWNLEY. So I just wanted to ask the other panelists if you have received late interest payments on any of the bills that have been resolved with you.

Mr. COOK. I don't believe so. I don't know that there is a process. You know, once the form that is sent in for the adaptive equipment on there, it is what the total is. You don't want to restart the process again to go back and add interest.

Ms. BROWNLEY. Yes.

Mr. COOK. So I don't know that our members know how.

I would like to clarify something that VA said about NGO-certified programs. They do have those with service animals right now. They do this on anything that VA doesn't have specialty, that are specialized industries, like ours. And we did not—sure, we would like for them to endorse our QAP program, quality assurance program, but we had just asked for basic criteria. We will settle for that.

Ms. BROWNLEY. And I hear you on that and also believe that something absolutely needs to be done.

Any late interest payments that you have received, Mr. Leist?

Mr. LEIST. Thank you for the question. No, we have not received any late interest payments at all.

But I want to take just a moment to clarify something I had in my testimony. I had stated that our hospital had decided not to contract with the Veterans Choice Program. And the reason we had done that was because we are not in the position, a small hospital in northern Arkansas, to contract for additional bad debt. In other words—and I want to state clearly that if the process improves we will contract to do those services.

But I also want to say that we will never turn away a veteran in our facility for any reason. So, until this gets resolved, we will continue taking care of those veterans, without question.

Ms. BROWNLEY. Well, thank you for that, Mr. Leist.

Mr. Montes.

Mr. MONTES. The main issue is with the Millennium bill and with the unauthorized care to the emergency—when you look at it, our company actually did an estimation for fiscal year——

Ms. BROWNLEY. I was just wondering if you had received any interest——

Mr. MONTES. No, we have not.

Ms. BROWNLEY [continuing]. Late interest payments.

Mr. MONTES. No, ma'am.

Ms. BROWNLEY. Thank you. Thank you.

Dr. Migliaccio, so who do you report to exactly?

Dr. MIGLIACCIO. I report to the Chief Business Officer.

Ms. BROWNLEY. To the Chief Business Officer. So is he, you know, the person who is ultimately responsible for all of these issues?

Dr. MIGLIACCIO. Well, the Chief Business Office reports up to the leadership over at VHA.

Ms. BROWNLEY. So the Chief Business Officer reports to the Secretary?

Dr. MIGLIACCIO. No, reports to one of the under secretaries.

Ms. BROWNLEY. To one of the under secretaries. Okay.

So do you have some sense—well, let me go back on the interest payment thing. So, if you are saying \$200,000 of late interest payments for this fiscal year, I don't know what the formula is for late interest, but, you know, what is the common denominator here? So how much of outstanding or late payments have there—I mean, what is the number for that? So is it a million dollars? So you have \$200,000 of late payments. Can you give me a sense of that?

Dr. MIGLIACCIO. Without—I really will have to get back with you on that. I don't know the interest rate and what it was based on.

Mr. ENDERLE. If I could supplement his comments, the interest payments are paid when the payment goes through the system. So, on the back end, when FMS cuts the check, if it is a contract payment, and only if it is a contract payment, would interest be applied, because we have a contract in place.

Ms. BROWNLEY. Okay. But I am just saying, if there are late payments of \$200,000, it is based on, you know, late payment to vendors and the contracts that you have, and I am looking for what that number is. Because, based on the testimony we have heard so far, it seems like, you know, it is millions and billions of dollars, and the \$200,000 late payment just doesn't add up for me. So I am just trying to sort of reconcile that.

Dr. Migliaccio, so, you know, you are new, and we recognize that it is hard to come into a new position in 4 months and truly get your arms wrapped around, you know, all of the problems and how to resolve it. And I think it takes a little bit more time than that.

But, you know, I am just curious, you know, to hear from you when you think you will get your arms wrapped around the whole problem and when you would be able to present, you know, a full plan to the committee and a timeframe of which you see success down the road. So can you give me just a little bit of a sense of that?

Dr. MIGLIACCIO. Well, in my—thanks for the question.

I mentioned before that I am framing the assessment that I am doing right now in the new position looking at our people, I am

looking at all of our processes, and I am looking at technology. I have kind of defined where are the areas that I want to look at, and claims is number one. Number two on my list is the Choice Program, and I want to work with PC3—

Ms. BROWNLEY. Do you have a sense of how many more people you need to hire?

Dr. MIGLIACCIO. Yes. When we onboarded—we onboarded about 2,000 positions we received for the transfer from our VISN and medical centers. It was really 1,982. We only have—

Ms. BROWNLEY. Those were unfilled positions?

Dr. MIGLIACCIO. No. Those are—those are the positions that came over. Not all the bodies were in those positions. So, currently, we have around 220 vacancies.

And I think, once we can get our staff hired, trained, and motivated on the work that we have in front of us, it is a very mission-driven organization—

Ms. BROWNLEY. So how long would that take, to hire 220 people?

Dr. MIGLIACCIO. Well, I am a little fast on how I approach an organization, so I would like to see it done yesterday. But I think it is going to have to take us a minimum of 3 months, working through the personnel system, to bring people on board.

Ms. BROWNLEY. So you believe by 3 months, though, you would be able to hire 220.

Dr. MIGLIACCIO. That is a goal. And I hope it is not a stretch goal.

Ms. BROWNLEY. I yield back, Mr. Chairman.

Dr. BENISHEK. Thank you.

Dr. Huelskamp, do you have any more questions?

Dr. HUELSKAMP. I do, Mr. Chairman. I wanted to follow up on an earlier issue and try to understand the distinction from the gentleman from VA, as far as authorized and unauthorized care.

Oncology, cancer care, is that generally preauthorized, or it is after the fact? Because the instance that has been shared with VA over a month ago that we are talking about, that was for cancer care.

Dr. MIGLIACCIO. Well, I will let Joe handle this. But if it is—if VA is going to send a veteran out from one of the medical centers into the community for care, we are going to get a preauthorization and make that appointment.

Dr. HUELSKAMP. I would hope so.

Dr. MIGLIACCIO. Yes, sir.

Dr. HUELSKAMP. But, again, this is—then, in that case, as I would anticipate, it is preauthorized, and we are still waiting back on the 120 days to scan the claim. And so—but that was always for unauthorized care.

So do you know—I mean, you have had this complaint from us for a month. I would presume it is preauthorized, then.

Mr. ENDERLE. If it is the oncology—

Dr. HUELSKAMP. Yes, sir.

Mr. ENDERLE [continuing]. It would be preauthorized, yes, sir. And that claim for outpatient services should be paid without any requirement for clinical documentation.

However, the clinical documents that there is a delay in scanning at this location, we are working with the local VA medical center

medical records department to make sure that we—and, in fact, we have moved some of our staff over there to assist them with scanning that clinical documentation to catch up with that backlog.

Dr. HUELSKAMP. That is what is confusing me. It is preauthorized, so scanning has nothing to do with it, the scanning delay. But that is what you told the oncology folks, that that is the reason. So that was inaccurate, then?

Mr. ENDERLE. Based on what I saw in that document, that would be inaccurate.

Dr. HUELSKAMP. Okay.

Mr. ENDERLE. They should be able to process the claim for a preauthorized claim without clinical documentation if it was for outpatient services.

Dr. HUELSKAMP. Okay. Well, we sent the issue to you weeks ago, and I don't know if you ever scanned in our email to you about it, but maybe that is the problem, as well. So we are still waiting for you to respond, to respond to them, and still maintaining with them somehow it is a scanning issue, but it clearly is not, then.

So how soon will you have an answer for making certain these veterans can still go to preauthorized oncology care without having to get in a vehicle and driving a long ways? So when will we get an answer for them?

Mr. ENDERLE. From what I understand, the answer to your inquiry is going through concurrence at this time.

Dr. HUELSKAMP. Describe "concurrence."

Mr. ENDERLE. Concurrence, our leadership concurrence. Once the response is concurred on, it will be sent to you.

Dr. HUELSKAMP. Okay. Describe that. Who is concurring in this?

Mr. ENDERLE. We draft the response to your inquiry; then it is routed through concurrence and released.

Dr. HUELSKAMP. The real issue, when will they get paid for helping the veterans and providing the care that you preauthorized?

Mr. ENDERLE. The paid part should have already been processed. In other words, if they already invoiced us for the oncology care, we received an EDI claim. That claim should have been processed and paid already—within 22 days, on average.

Dr. HUELSKAMP. Okay. It has not. I mean, that is my question.

Mr. ENDERLE. Okay.

Dr. HUELSKAMP. It has been more than 22 days since we contacted you about that. So you should be paying interest, significant amounts of interest, on that.

But, clearly, you don't know. It hasn't been paid that we know of.

Mr. ENDERLE. We need to look into it to see what the status of that claim is, sir.

Dr. HUELSKAMP. Okay.

And another issue, just trying to clarify and understand the process. I have another issue with a doctor of chiropractic, that you called him and said, hey, would you treat this patient for us? So I presume it is preauthorized.

Mr. ENDERLE. Yes, sir.

Dr. HUELSKAMP. So, again, it is not a scanning issue.

They started treatments in September and still waiting. You called him, said, hey, can you take care of him because it is a long ways from Wichita.

So is this the case, again, that—not a scanning issue—it simply is a payment problem in this whole section of preauthorized care?

Mr. ENDERLE. It sounds to me that that is a payment problem, yes, sir.

Dr. HUELSKAMP. Okay.

Thank you, Mr. Chairman.

Dr. BENISHEK. Mr. Coffman.

Dr. Abraham, any questions?

Dr. ABRAHAM. Yes. Thank you, Mr. Chairman.

The three witnesses from the private sector, I am assuming, with your testimony, that the fiscal intermediary such as Medicare and the tracker used would be certainly better than this system that we have now. Would that be a statement we could agree with?

Mr. LEIST. Yes, sir.

Dr. ABRAHAM. Okay.

And I will go to you, Doc and Mr. Enderle, that we understand, and I have no doubt, personally, that your heart and mind is in the right place for our veterans. I think everybody in this room and on this panel agree. But, again, we are dealing with government bureaucracy. And I won't be quite as nice, I guess, as Ms. Brownley as far as giving you guys time to hire.

Why not take the \$200,000 on interest—and we know in this room it is going to be a lot more once that back money comes in—pay all the claims, and then go back to the providers on the unclaimed claims and maybe let them reimburse you?

We are talking about veterans that are getting—I have a list here of veterans that are having negative credit ratings. I would imagine—and you can correct me, Mr. Enderle, if I am wrong—that the number of veterans that don't qualify for 911 services are very small compared to the overall.

Why not pay the claims, use some of this money we are paying in interest, and then, if you do find an unclaimed claim that does not qualify, so to speak, well, go to Acadian, go to Cook, and then let them reimburse? But don't hold up millions of dollars that these gentlemen are providing for our heroes, trying to do the right thing, and they are getting left holding the bag.

I have a surgical hospital in my district, as I have said, that, to their disappointment, to their severe disappointment, have had to stop servicing veterans. We wrote VA about it. I have yet to receive any response. And this goes back a few months ago that I have yet to get a response as to why this has happened.

But, again, we go back—this is just such an unacceptable procedure. I am just looking for some comments here.

Mr. Enderle, I will take yours.

Mr. ENDERLE. Thank you for the question. That is a very good question. I wish we could just process the claim for payment and issue the check on behalf of our veterans, who deserve the best from us.

Because of regulatory requirements, we have to determine eligibility criteria of that individual veteran who the claim is submitted on. And that process requires us, based on regulation, that if that

veteran does not have preapproval or preauthorization, that claim, in essence, becomes what we call an unauthorized——

Dr. ABRAHAM. Well, I understand the process, but is that regulation dictated by VA itself? Is that the rule that VA put in place?

Mr. ENDERLE. It is both regulation and statute. So it is a requirement that we have to determine eligibility based on those claims that had not been prior-authorized. That prevents us, based on the eligibility, to make that lump-sum payment that you are referencing.

Dr. ABRAHAM. Well, perhaps we can work on that.

Mr. ENDERLE. Yes, sir.

Dr. ABRAHAM. Okay.

Thank you, Mr. Chairman. I yield back.

Dr. BENISHEK. All right. Thank you, Dr. Abraham.

I just have one more question for—maybe Mr. Enderle can answer it. I don't know if you can do it, Doctor.

But I just got some information that the non-VA care budget for fiscal year 2015 was set at, \$5.4 billion, but then apparently VA withdrew \$700 million from that to cover hepatitis C medication that has become expensive for VA. We are also told that is why VA is making the Choice Program the default option for outside care.

Is that true? Anybody aware of that?

Mr. ENDERLE. I am not aware of——

Dr. BENISHEK. Are there any other deductions from this account for other VA expenses that anyone is aware of?

Mr. ENDERLE. I am not aware of any other deductions.

Dr. MIGLIACCIO. I am not either.

Dr. BENISHEK. So what I would like to get to, then, is what is the money remaining in that non-VA care fund for the remainder of the fiscal year? So that is the number that I am expecting from you all within the next month, okay?

Dr. MIGLIACCIO. Chairman, is that under the Choice fund?

Dr. BENISHEK. Well, no. No, there is the non-VA care budget.

Dr. MIGLIACCIO. Okay.

Dr. BENISHEK. And then, we have been told that the Choice has now become the default non-VA care option because of the diminished amount of this fund due to other expenses. And I am just trying to find out if this fund is being used for other VA expenses and making it more difficult to get outside care.

Dr. MIGLIACCIO. Not to my knowledge, but we will check into it, sir.

Dr. BENISHEK. Well, I understand that hepatitis C treatment is becoming expensive, but we need to deal with that and not cut back on this part of care, as well.

Thank you all for being here today. I really appreciate it. It has been enlightening. I appreciate the providers' being here today and, actually, as many have said, for your willingness to be here today and take the heat from VA for what you are doing. If you hear from them in a negative fashion, I would appreciate hearing from you.

And I appreciate both your presence here today, Doctor and Mr. Enderle. I know what kind of a situation you are in, but I am trying to hold people personally responsible for what they are doing here. Because, typically, we get great responses from VA, but then 6 months later, nothing has changed and there is a different person

giving us a great response. So it is very frustrating on my part. The accountability of individuals is paramount here.

So thanks, all, again.

The subcommittee may be submitting additional questions for the record, and I would appreciate your assistance in assuring expedient responses to those inquiries.

Dr. BENISHEK. If there are no further questions, the panel is now excused.

And I ask unanimous consent that all members have 5 legislative days to revise and extend their remarks and include extraneous material.

Without objection, so ordered.

The hearing is now adjourned.

[Whereupon, at 11:35 a.m., the subcommittee was adjourned.]

APPENDIX

PREPARED STATEMENT OF ASBEL MONTES

My name is Asbel Montes and I am the Vice President of Reimbursement and Government Affairs for Acadian Ambulance Service, the largest private, employee-owned ambulance service in the nation. The Chairman & CEO of our company, Richard Zuschlag, founded the ambulance service division in 1971 with eight Vietnam veterans. Today, we now have over 4,000 employee owners, with over 400 of those owners being military veterans.

I am honored to sit before you today to represent not only the industry, but even more so, the veterans we serve.

Background

Prior to coming before you today, our company, along with American Medical Response, the largest public ambulance provider in the nation, and the American Ambulance Association have worked diligently with our Congressional delegations, other healthcare stakeholders, the Veteran Integrated Network Services (VISNs), as well as the national leadership at the VA to assist, recommend and frankly demand that the VA's internal processes be updated and modified to ensure that they are fulfilling their intended purpose, but also not placing financial burden on the men and women who have served our nation so selflessly.

Despite these efforts, we have not seen any significant positive movement from the VA and therefore find ourselves here today.

For a real life look at the issue, please allow me to provide one example that a veteran in Louisiana experienced who called 911 for emergency medical care and transport in 2014. We filed a claim and provided all necessary medical records and appropriate documentation within 30 days to the VA. We sent this information via certified mail. The VA signed for it confirming receipt five days later. Almost a year later on March of 2015, the veteran appeared on two local TV channels describing how his claim was still unpaid. He was subsequently contacted by a VA representative on March 18, 2015, indicating that his claim would be paid and he would receive notification. The claim was finally processed and paid in April of 2015, over a year and 3 months from the time the claim was originally filed.

There are many more examples just like this one that could be given by providers and veterans alike across the nation, but suffice it to say, the GAO report in 2014 which highlighted issues regarding excessive claims processing times and paperwork requirements for non-VA providers is absolutely correct. This problem is especially acute for the majority of ambulance service providers that serve as the local 911 responders in their communities, who are prohibited from refusing emergency treatment for any patient, regardless of payor source or ability to pay. This failure to pay providers in a timely and accurate manner puts providers in the difficult position of having to bill veterans for emergency treatment, placing an unfair financial burden on the veteran due to the lack of response, invalid denial or payment by the VA.

Our previous efforts at addressing this issue have included numerous inquiries sent from Congressmen and Senators in many states and the responses from the VA have remained wholly inaccurate and inadequate.

My colleagues and I are not ignorant to the magnitude that this issue presents for the VA. However, after numerous offers of assistance and requests for relief from

the private and public sector, we have seen very little change. In fact, our company, American Medical Response, and many members of the American Ambulance Association have seen a recent escalation of the problem with our accounts receivables due from the VA growing in excess of \$30M outstanding over 90 days.

VISN 16 has sent reports to our Congressional Delegates with a number that would indicate improvement, but our data clearly indicates the opposite. On May 14th of this year, we had yet another conference call with VISN 16, specifically the Flowood, MS office and requested that they provide us with all claims filed to them since 2012 in order to reconcile our records with theirs. That audit, which was completed on last Tuesday, indicated that they showed no record of 768 claims which were sent certified mail with confirmation of receipt by the VA.

Solution

The federal government has a responsibility to ensure that our veterans receive the best healthcare we can provide. It also has a responsibility to ensure they are not required to bear an unjustified financial burden because the VA fails to pay non-VA providers in a timely and accurate manner. It is our recommendation that Congress remove all claims processing for non-VA providers from the Department of Veterans' Affairs and place it with a single Fiscal Intermediary, providing guidelines and policies to address the issues stated here today. This step would ensure consistency, efficiency and expertise in personnel as well as sufficient dedicated resources to process claims timely. Several other government programs, including Medicare and Tricare, utilize this strategy successfully. Please note that time is of the essence.

Thank you for giving me this opportunity to provide information and to serve those who have sacrificed so much for our nation. I look forward to answering the Committee's questions and serving as a resource as the Committee's work continues beyond this hearing.

PREPARED STATEMENT OF VINCE LEIST

On behalf of the American Hospital Association's (AHA) nearly 5,000 member hospitals, health systems and other health care organizations, and its 43,000 individual members, I thank you for the opportunity to testify on the Department of Veterans Affairs' (VA) ability to promptly pay non-VA providers and the challenges hospitals and health systems throughout the country have faced in receiving payment for services provided to our veterans.

I am Vince Leist, president and CEO of North Arkansas Regional Medical Center (NARMC) located in Harrison, Ark. NARMC is county-owned and operated by a not-for-profit health care system serving the comprehensive health needs of rural communities in northern Arkansas and includes a 174-bed hospital and three rural clinics. We also provide hospice, home health, urgent care and ambulance services and operate six primary care clinics. With 101 staff physicians and nearly 800 employees, NARMC is the second-largest employer in Harrison County. Like every community in America, we are proud of the men and women who have served our great nation, and we are eager to serve them. These brave veterans are our neighbors, and as a small community, we know them well and are honored to care for them in their time of need.

America's hospitals strive to ensure patients get the right care at the right time, in the right setting. As such, they have a long-standing history of collaboration with the VA and are eager to assist the department, and our veterans, in any way they can, including providing care through the Veterans Choice Program, the Patient-Centered Community Care (PC3) program, direct contracting with the VA and, of course, serving the urgent health care needs of our veterans as they arise when there is or is not a contract with VA in place. However, hospitals' continued inability to obtain timely payment from the VA and its contractors hinders access to care for veterans who need non-VA services and undermines the viability of non-VA hospitals across the country and the essential services they provide to their communities.

We also are concerned about the process by which the VA processes claims. Medical records have been lost or unaccounted for, leading to questions of privacy for our veterans. Unfortunately, there are no prompt payment laws for care that is provided to veterans if the hospital does not have a contract, and there is limited oversight of how these claims are processed. In addition, many veterans worry about claims that are not paid promptly or are left unpaid, and they are left in a difficult

position of trying to get claims paid, often while battling illness. It is an untenable position for both veterans and hospitals.

Below, I outline why the lack of prompt payment impedes access to care for veterans and offer recommendations to address this important issue to ensure that high-quality care is provided to veterans and our communities.

Background On Veterans Choice Program

The Veterans Choice Program is a new, temporary benefit allowing some veterans to receive health care from non-VA health care providers rather than waiting for a VA appointment or traveling to a VA facility. It was authorized under the Veterans Access, Choice, and Accountability Act of 2014 and provides \$10 billion for non-VA medical care to eligible veterans until the required end date of Aug. 7, 2017. The temporary program will end early if the allocated funds of \$10 billion are used prior to that date.

While we understand that the VA had an extraordinarily short timeframe in which to implement the program, hospitals, as well as veterans, have faced many roadblocks when attempting to provide and access care under the program. These roadblocks have resulted in a very small number of eligible veterans being able to access the program. With our shared goal of ensuring that America's veterans receive the care they need at the time they need it, the AHA in March provided the VA with suggestions for improving the Veterans Choice Program with respect to the mileage requirement, timely payment of claims and contracting to provide care.

LACK OF PROMPT PAYMENT HINDERS ACCESS TO CARE FOR VETERANS

Non-VA providers have experienced and continue to face problems obtaining timely payment from the VA and its contractors. This hinders access to care for veterans who need non-VA services and is a disincentive for non-VA hospitals to either participate in the Veterans Choice Program, the PC3 program or to contract with the VA to provide healthcare services to veterans.

Last June, a witness from the Government Accountability Office (GAO) testified at a House Committee on Veterans' Affairs hearing on claim-processing discrepancies that delayed or denied payments for health care provided by non-VA providers. According to GAO, these delays or denials create an environment where non-VA entities are hesitant to provide care due to fears they will not be paid for services provided. In addition, a March 2014 GAO report found a non-VA hospital often either received no response after claims were sent to the VA or experienced lengthy delays, in some cases of years, in the processing of their claims. The hospital had approached the VA to try to discuss ways to improve the claims process, but those efforts were unsuccessful.

Last month, at a hearing before the full House VA committee, VA Deputy Secretary Sloan Gibson acknowledged the lack of timeliness in promptly reimbursing non-VA hospitals and expressed his commitment to improve the payment process. Hospitals and health systems welcome that commitment from the VA leadership; however, many non-VA hospitals have outstanding payments spanning many months—and some date back for years—so it is essential to work quickly to solve the problem of not paying promptly.

NARMC strongly believes that we need to serve the needs of our veterans. The closest VA health facility to NARMC is a small VA outpatient clinic down the street from the hospital. The closest VA hospital is 70 miles away, and the nearest non-VA hospital is 60 miles away. NARMC regularly accepts patients who are seen at the VA outpatient clinic but are too sick to travel to the VA hospital or any other hospital. These veterans are referred to our hospital by the VA outpatient physician. We also regularly see veterans who come to our emergency room because they have an urgent health care issue. Our mission is to heal, and while we wish we did not have to focus on the financial responsibility of running a hospital, we must—that is the only way we can keep our doors open. While we are very dedicated to serving the veterans in our community, and we accept each and every one who walks through our doors, we have decided against contracting with the VA due to slow or no payment for claims and the bureaucracy involved with getting claims through the payment process.

Since 2011, NARMC has 215 claims totaling more than \$750,000 that have not been paid by the VA. NARMC has attempted to work with the VA to resolve these claims; however, those efforts have resulted in, among other frustrations, long periods on hold to speak to VA service personnel, limitations on the number of cases to be discussed per phone call and lost medical records. In Arkansas, NARMC is not alone in not receiving prompt pay for services it provides veterans. More than 4,400 claims – many dating back more than three years – totaling \$24 million is currently owed to 60 Arkansas hospitals that are non-VA providers, according data from the Arkansas Hospital Association. Our elected officials have attempted to as-

sist us with this difficult situation, but those efforts have had limited success. Additionally, in March, the VA reported a national backlog of more than \$878 million in delayed payments for veterans' emergency medical services delivered by non-VA providers.

Even though NARMC has not been paid by the VA for services going back four years, our hospital continues to provide care for the veterans in the communities we serve. However, lack of prompt payment from the VA combined with continued reductions to Medicare and Medicaid payments for hospitals are jeopardizing access to care for patients. From 2010 to 2014 alone, Medicare and Medicaid payments for hospital services were cut by more than \$121 billion. In addition, government programs continue to pay less than the cost of providing services to their beneficiaries—underpayment by Medicare and Medicaid to hospitals was \$51 billion in 2013 alone. Lack of adequate and prompt payment is particularly challenging for small and rural hospitals that already are contending with challenges such as remote geographic location, small size, limited workforce, physician shortages and often constrained financial resources.

If the VA does not pay claims promptly and further reductions in payments for hospital care continue, NARMC would be forced to reduce or eliminate services offered to patients or seek assistance from already-strapped counties in Arkansas. For example, our hospital offers life-saving ambulance services to four counties in rural Arkansas with no support from tax dollars, but those services could be scaled back or eliminated. Many hospitals throughout the country would have to make similar decisions, resulting in decreased access to care for patients and communities. We want to continue to provide essential health care services to our communities, including our veterans, but will not be able to do so without the proper resources, including prompt payment from the VA.

Recommendations to Ensure Prompt Payment

As required by the Veterans Access, Choice and Accountability Act, the VA must establish a nationwide claims processing system to receive requests for payment and to provide accurate and timely payments for claims. However, an interim final rule implementing the law does not set forth the timeframes within which the VA must review claims and make payment. The VA and its contractors should commit to paying non-VA hospitals in a timely manner for Veterans Choice Program services, as well as other services provided to veterans. Specifically, the VA should:

- Review claims as soon as practicable after receipt to determine whether they are proper. When a claim is determined to be improper, the department should return the claim to the hospital as soon as practicable, but no later than seven days after its initial receipt. The VA also should specify the reasons why the claim is improper and request a corrected claim.
- Pay claims within 30 days of the receipt of a proper claim.
- Make interest payments to hospitals when claims are not paid according to the 30-day standard.

In addition, Congress should consider requiring the VA to develop a metric to measure effectiveness in its claims processing, including soliciting feedback from non-VA providers, and have the VA report to Congress on a regular basis the information it obtains on the effectiveness of its claims processing.

Conclusion

The VA health system does extraordinary work under very difficult circumstances for a growing and complex patient population. While the system is working to overcome operational challenges, America's hospitals are eager to assist the department, and our veterans, in any way they can. The AHA stands ready to work with the committee to ensure prompt payment to non-VA providers so that hospitals can continue to provide vital services to veterans and all of the patients and communities they serve.



Sam Cook

**President
National Mobility Equipment Dealers Association**

June 3, 2015

**United States House of Representatives
House Committee on Veterans' Affairs
Health Subcommittee Hearing
"Assessing VA's Ability to Promptly Pay Non-VA Providers"**

Written Statement

STATEMENT OF THE
NATIONAL MOBILITY EQUIPMENT DEALERS ASSOCIATION
SUBMITTED AT THE HEARING OF THE HEALTH SUBCOMMITTEE
OF THE HOUSE COMMITTEE ON VETERANS' AFFAIRS

“ASSESSING VA’s ABILITY TO PROMPTLY PAY NON-VA PROVIDERS”

June 3, 2015

I. Organization Description

NMEDA is a non-profit trade association dedicated to expanding opportunities for people with disabilities (many of whom are veterans) to safely drive or be transported in vehicles modified with mobility equipment to fit their special needs. Formed in 1989, the organization is comprised of more than 600 members including mobility dealers, mobility equipment manufacturers, vehicle alterers/second stage manufacturers, original equipment automotive (OEM) manufacturers, driver rehabilitation specialists, healthcare, and other industry professionals. NMEDA promotes and supports these professionals engaged in the modification of quality transportation for people with disabilities. Since its inception, NMEDA member mobility dealers have worked with the VA to supply disabled veterans with safe and reliable transportation in order to help them maintain an active and productive lifestyle.

Within NMEDA there are more than 300 highly qualified mobility dealers who specialize in modifying, selling, and servicing specially equipped vehicles so that people with physical disabilities can safely drive on public roads and highways. Each NMEDA member dealer is required to follow the rules of our Quality Assurance Program (QAP); adhere to the NMEDA Guidelines; and submit to a yearly audit by a third party auditor in order to ensure that all rules and guidelines are being adhered to.

The QAP rules require NMEDA members to:

- Maintain Product, Completed Operations, and Garage Keepers Insurance
- Employ technicians who are trained and certified for the equipment they sell, install, and service
- Employ certified welders to perform all structural modifications to vehicles

- Provide 24-hour emergency service to all customers
- Meet shop facility and equipment requirements (*e.g.*, provide and maintain ADA-compliant facilities and showrooms)
- Possess and use four-corner scales to make safety adjustments to vehicles with new equipment installations
- Undergo a yearly, independent inspection/audit process to ensure compliance with NMEDA Guidelines, the National Highway Traffic Safety Administration's (NHTSA) Federal Motor Vehicle Safety Standards (FMVSS) and "Make Inoperative" mandates, and all applicable provisions of the Americans with Disabilities Act.
- Abide by the decision(s) of the Mediation Committee when consumers, dealers and/or any other person or entity logs a complaint.

It is important to note that all NMEDA dealer members are small business owners, varying in size from three employees to up to 15 employees per location. On average, NMEDA estimates that each dealer location produces approximately \$2.5 million in annual gross revenue through the sale of modified vehicles, mobility equipment installations, and service and upkeep. Prompt payment is extremely important to the majority of our retail members; in the absence of prompt payment, NMEDA member small businesses struggle to pay employee salaries, to pay expenses, and to remain operational. Approximately 75% of NMEDA's member dealers work with their local/regional VA facilities in some capacity. In some cases the VA represents as much as 25% of a dealer's annual income and, over time, the VA's slow payment practices have resulted in NMEDA members becoming hesitant, unwilling, or simply unable to provide care to veterans due to concerns they will not be paid – promptly or perhaps even at all – for the services they provide.

II. Overview of Prompt Payment Issues

This document is being provided by the National Mobility Equipment Dealers Association (NMEDA) as testimony to the payment practices of the VA relative to the Prosthetics Department's Automotive Adaptive Equipment (AAE) program and the Veterans Benefits Administration's Auto Grant program.

NMEDA member mobility dealers are proud and honored to serve our nation's veterans and we appreciate the business we get through the VA on their behalf. However, the VA's process for ordering and purchasing a modified vehicle and/or equipment for veterans with disabilities is often a frustrating and inefficient one. These difficulties are particularly evident when considering the process by which non-VA providers receive payment for services rendered.

The Prompt Payment Act (5 CFR Part 1315) is meant to ensure that valid and proper invoices submitted by vendors are paid on time by federal agencies. Per the Prompt Payment Act, a payment is due on whichever of the following four conditions applies:

1. The date specified in the contract;
2. In accordance with discount terms when the vendor has offered a discount and the agency has accepted those terms;
3. On an accelerated schedule when the conditions for accelerated payment apply; or
4. 30 day after the agency has received a proper invoice.

All invoice payment due dates referenced in this statement are subject to condition 4.

While not all VA facilities and VISNs struggle with promptly paying non-VA providers, NMEDA can testify to the fact that many are slow to pay mobility dealers for products and services rendered to veterans with disabilities. The Prompt Payment Act sets a standard of 30 days for properly submitted invoices to be paid, but this standard is rarely met by the VA. As past-due invoices continued to pile up, NMEDA initiated a Past-Due VA Invoice Program in an attempt to help our members receive reimbursement for overdue payments from the VA. The Past-Due VA Invoice Program has been operational for approximately five years and during that time over \$34 million in past-due invoices – many of these invoices months or even years past-due – have been sent to the VA Central Office. Unfortunately, NMEDA has yet to receive any indication that VA's payment procedures have improved.

III. Historical Perspective

The slow payment practices of the VA have been an issue of great concern ever since NMEDA's inception over 25 years ago. Over the years there have been a number of attempts to convince VA that slow payment of invoices should be dealt with at the national level. Time and

again, dealers appealing to their local VAs were told that past-due invoices would be paid once they were no longer “hung up” at the regional office or “being processed through VA’s system.”

In 2010, NMEDA met with the (then) Chief of Prosthetics at VA, Fred Downs. After citing NMEDA members’ concerns with slow payment, Mr. Downs asked NMEDA to produce the past-due invoices from its membership so that VA Central Office could help get them paid. NMEDA sent an email to its membership asking them to submit VA invoices over 60 days past-due and, within 10 days, NMEDA received 547 invoices from 87 members totaling \$3,954,051.22 in past-due payments from VA. 44% of those invoices were over 120 days past due and 27% of those invoices detailed past-due payments of over \$5,000 (some in the tens of thousands). The numbers and figures were shocking – and VA agreed – so NMEDA organized the invoice data by VA facility and sent it to the Prosthetics Department’s Central Office Staff for handling. The invoices were then sent from VA Central Office to each local facility with a directive to process the invoices as soon as possible. The feedback from NMEDA membership was positive and VA’s Prosthetics Department agreed to continue the process on a quarterly basis.

Since 2010 the NMEDA Past-Due VA Invoice Program has submitted fourteen Past-Due Reports to the Prosthetics Department for processing. While it is admirable that the Prosthetics Department has been responsive to NMEDA’s Past-Due VA Invoice Program, it must be stated that no real progress has been made by VA in terms of actually improving the VA payment process and its accompanying procedures. NMEDA continues to request past-due invoices from our members, and we continue to receive past due invoice submissions totaling millions of dollars.

In 2012, VA asked NMEDA to submit separate reports for the Prosthetics AAE program and the VBA Auto Grant program. In 2014, the Prosthetics Department further modified the program by requesting that NMEDA only send invoices over 120 days past due. While this request ultimately reduced the number of invoices used as data points, the Past-Due Invoice Reports that were submitted in 2014 still documented an average of \$1.5 million in past-due VA invoices.

While NMEDA appreciates the VA’s efforts, the agency was and still is only addressing the symptoms. NMEDA members have experienced no meaningful or consistent improvement in the payment processing timeline.

IV. **NMEDA's Past-Due VA Invoice Program Facts**

- Fourteen Past-Due VA Invoice Reports have been submitted to the VA Central Office in Washington, DC, since November 2010.
- Overall, 3,907 past-due VA invoices totaling \$34,332,600.88 have been submitted.
- While the average number of days past-due is approximately 160 days (five months), there are numerous invoices over three years past-due.
- It is estimated that 80% of the total amount past-due (\$27,466,080.70) can be attributed to the AAE Program administered by the VA Prosthetics Department. It is estimated that 20% of the total amount past-due (\$6,866,520.18) belongs to the Auto Grant Program administered by the VBA.
- Each dealer member averages \$67,318.83 outstanding (past-due) for each Past-Due VA Invoice Program Report. However, some dealers show several hundred thousand dollars in past-due invoices on any given report.
- In the latest Past-Due Invoice Report submitted to VA in February of 2015, one invoice was 2,368 days past-due (over 6 years) and 16% (34 out of 147 invoices) were over one year old. All invoices were complete and properly submitted, but none have been paid. In addition, complete and properly submitted invoices averaged nine months (271 days) past-due with over 63% of the invoices over 180 days past-due.

| NMEDA Past Due VA Invoice Program Summary | | | | | | | | |
|---|--------------------|------------------|------------------------|----------------|-------------------|------------------|-----------------|------------|
| Date | Number of Invoices | Total | Over 120 Days Past Due | % Over 120days | Dealers Reporting | Prosthetics 1394 | VBA Auto Grant | |
| 2/10/2015 | 147 | \$ 2,237,902.13 | 147 | 100% | 27 | \$ 1,962,487.13 | \$ | 257,585.00 |
| 8/6/2014 | 134 | \$ 1,680,321.97 | 134 | 100% | 24 | \$ 1,406,570.97 | \$ | 273,751.00 |
| 4/10/2014 | 109 | \$ 1,446,698.47 | 109 | 100% | 20 | \$ 1,170,444.22 | \$ | 275,869.25 |
| 10/5/2013 | 322 | \$ 3,433,267.75 | | | 32 | \$ 2,459,988.09 | \$ | 973,279.66 |
| 8/11/2013 | 35 | \$ 340,770.48 | | | 5 | \$ 264,246.81 | \$ | 76,523.67 |
| 4/2/2013 | 279 | \$ 2,267,301.59 | | | 32 | \$ 1,947,005.84 | \$ | 320,295.75 |
| 10/22/2012 | 287 | \$ 2,484,545.82 | | | 34 | \$ 1,868,045.82 | \$ | 616,500.00 |
| 5/23/2012 | 335 | \$ 2,721,484.62 | | | 36 | \$ 2,192,984.62 | \$ | 528,500.00 |
| 2/2/2012 | 481 | \$ 4,900,831.81 | | | 59 | | | |
| 10/3/2011 | 267 | \$ 2,162,073.65 | 104 | 39% | 46 | | | |
| 7/19/2011 | 256 | \$ 1,835,589.12 | 138 | 54% | 22 | | | |
| 5/9/2011 | 312 | \$ 2,721,484.62 | 170 | 54% | 35 | | | |
| 1/28/2011 | 396 | \$ 2,146,277.63 | | | 51 | | | |
| 11/22/2010 | 547 | \$ 3,954,051.22 | 243 | 44% | 87 | | | |
| | 3907 | \$ 34,332,600.88 | | | 510 | \$ 13,271,773.50 | \$ 3,322,304.33 | |
| | | | | | | 80% | 20% | |

V. Lack of Policy Uniformity Contributes to Slow Payment

Claims processing and payment procedures vary widely from one VA facility or VISN to the next. For example, a NMEDA member has reported that a properly submitted invoice will be paid within 30 to 35 days in Tennessee, while it can take six to eight months for a properly submitted invoice to be paid in Illinois and Indiana. Such inconsistent invoice processing amongst VISNs serves to illustrate the VA's lack of uniform procedures and its own inability to implement and enforce prompt payment policy. The following are several additional examples of inconsistent VA policies and procedures negatively impacting the timely payment of non-VA provider invoices with respect to VA's Auto Grant and AAE programs:

California

- A NMEDA dealer has two stores in the Los Angeles Metro Area and works with four different VA facilities. This member currently has thirteen outstanding invoices totaling \$151,840.79 in past-due payments and averaging 355 days past-due (the oldest one dating back 648 days). This dealer has made numerous attempts to resolve the past-due invoices with the various VA facilities, to no avail. All thirteen of the invoices in question were submitted to the Prosthetics Department Central Office Staff under the NMEDA Past-Due VA Invoice Program, also to no avail. Neither the VA Central Office in Washington, DC, nor any of the local VA offices, has communicated with the dealer in an effort to resolve any of the thirteen past-due invoices.
- A different NMEDA member dealer with three stores in the Los Angeles Metro Area has five outstanding veteran accounts (nine separate invoices) totaling \$69,000 in past-due payments averaging 196 days past-due (all invoices are over 120 days past-due). This mobility dealer continues to work for the veterans – and, by extension, with the VA – despite the fact that VA has still not paid for nearly \$70,000 of previous work.

Arizona

- A veteran receiving care at the Phoenix VA Medical Center suffered from ALS. The mobility dealer had received prior authorization from the VA and the veteran had

signed the 1394 and VA-4502 forms. The van was delivered to the veteran's home on October 27, 2011 and the dealer hand-delivered the paperwork to the VA within five working days of the van's delivery date. However, within two months, the veteran passed away. After helping the veteran's widow re-sell the van, this mobility dealer did not receive the 1394 payment until six months later. The VA-4502 payment of \$18,900 was not made until thirteen months later. Throughout the so-called payment process, the VA stalled the payments to this dealer because the veteran had died before the claims were paid, even though the veteran was alive when he received the vehicle. In this case, the VA did not even follow its own payment process. This example also underscores VA's lack of a policy to accelerate the AAE/Auto Grant process in cases where time is critical (*i.e.*, terminal illness).

Kentucky

- A veteran submitted Auto Grant Form 4502 for approval on March 22, 2012, and the VA signed off its approval on May 29, 2012. The veteran then used the auto grant to purchase a vehicle. Four months later, the veteran was informed that the VA had erroneously signed off on the 4502 and that he was not in fact eligible to purchase a vehicle with VA auto grant funds. Having acted in good faith on an approved Auto Grant and after numerous attempts to resolve the situation, the Kentucky dealer has not been paid as of this testimony's writing because the VA has refused to honor its mistaken approval of a duplicate 4502. This example is an excellent illustration of the VA's inability to resolve payment issues in a timely manner, and highlights VA's lack of central control over program approvals. The Kentucky dealer still has no clear path for remedy or resolution.

Some VA facilities do manage to process invoice payments in a timely manner. However, a number of facilities consistently show up in NMEDA's Past-Due VA Invoice Report with member claims reaching hundreds of thousands of dollars. Examples from just one past-due report include:

- One mobility dealer in Durham, NC was owed \$247,651 from just one VA facility that includes 15 separate invoices all past due an average of 150 days (five months).

- A San Antonio mobility dealer was owed \$295,957 from one VA facility that includes 55 separate invoices all past due an average of 312 days (over ten months).
- A NMEDA dealer with stores in multiple states was owed a total of \$645,284 from five different VA facilities over four states. This scenario included 68 separate invoices all averaging 396 days (over thirteen months) past-due.

These amounts are much too high for a small business to have outstanding (past-due) at any time. It is unfortunately not unusual for NMEDA dealers to report over \$100,000 in past-due VA payments at any given time. Over the years that NMEDA has been reporting past due invoices to the VA, San Antonio, Richmond, Chicago/Hines, Houston, Atlanta, Richmond, and San Diego have consistently shown up as the biggest offenders.

It is important to note that specific mobility dealers' names have been omitted from this written statement due to fear of VA retribution and, by extension, potential loss of veteran business as punishment for trying to collect what is owed to them. In fact, NMEDA has received several reports of retaliatory action from a VISN after the VA Central Office instructed that local facility to pay its past-due invoices. Furthermore, some NMEDA members have begun to decline work from the VA because they simply can't afford to bankroll the VA's sluggish and inconsistent invoice processing procedures. As one NMEDA member put it: "If it wasn't for the people we serve [the veterans], we would just walk away from doing business with the VA."

As more qualified NMEDA QAP accredited dealers decline to work with the VA, the number of "qualified" AAE suppliers that the VA can call upon is diminishing. This means that suppliers who may not adhere to NMEDA's high standards – and in some cases do not adhere to any quality or safety standards at all – will be called upon to address our veterans' automotive mobility needs. Less-than-qualified suppliers provide less-than-adequate service, which leads to increased expense and administrative time as more and more problems with faulty equipment and improper installations arise. Such scenarios further exacerbate the inconsistencies in processing veteran claims and mobility dealer invoices. NMEDA's Quality Assurance Program ensures that the job is done right the first time, and such qualified and competent mobility dealers should not have to experience the strain of not being paid within a reasonable time frame.

VI. **Related VA Inefficiencies Put Veterans, American Public at Risk**

- **No Quality/Safety Standards for AAE Providers, Outdated VA Handbook 1173.4**

The VA requires a JCAHO certification in order to sell a veteran a bottle of oxygen, but there are no enforceable requirements in place for an individual or business to sell, install, and/or repair high-tech vehicles and/or complex driving systems that allow veterans with service-connected disabilities to operate motor vehicles on public roads and highways. As a result of this lack of standards, VISNs employ the use of inferior vendors (*e.g.*, individuals working out of home garages/parking lots/mobile trucks, individuals and businesses completely lacking insurance, individuals and businesses employing uncertified welders and technicians, etc.). The VA's lack of basic, minimum standards regarding the procurement, installation, and maintenance of AAE precipitates poor-quality installations and safety concerns. This is also an example of fiscal irresponsibility as the VA is spending taxpayer dollars for inferior services (and the inevitable correction thereof by a "qualified" provider).

- **VA's Inappropriate Reliance on NHTSA Modifier Registration List**

The VA currently refers veterans to the NHTSA Modifier Registration List to find a "qualified" mobility dealer. Unfortunately, the NHTSA Modifier Registration List was never intended for this purpose and is completely inadequate as a referral source. While NMEDA has had a long and positive relationship with NHTSA, and our Guidelines and QAP Rules are all designed to ensure that our mobility dealer members are in compliance with FMVSS, simply registering on NHTSA's site does not in any way infer or ensure that the registrant is following any kind of quality or safety program. To direct veterans to the NHTSA Modifier Registration List means VA is referring veterans to suppliers who may not have all (or any) of the qualifications, tools, and insurance necessary to provide the services and/or install the equipment the veteran requires. An unqualified vender would *hopefully* acknowledge that they are unqualified, but there is no guarantee. The unfortunate reality of the NHTSA Modifier Registration List is that any individual or company can secure themselves a spot on the Mobility Modifier Registration List, thus allowing them to make certain quality and safety certifications despite the fact that they are, in some instances, completely untrained and unqualified to do so. Furthermore, the NHTSA Modifier Registration List is woefully inaccurate (*e.g.*, outdated addresses, incorrect

business names, modifier no longer in business, etc.) yet VA continues to refer veterans to this list as the veterans search for a “qualified” mobility dealer.

- Glaring Inconsistencies Amongst VISNs

VISNs tend to operate based on their own individual interpretations of VA operational procedures with respect to bidding jobs, processing invoices, etc. This variation can lead to problems of product quality and reliability, service expertise, increased long-term costs, veteran safety, and prompt payment of invoices, among others.

The above inconsistencies, in addition to VA’s inconsistent ability to promptly pay non-VA providers, will inevitably have a negative impact on the quality and safety of the service-connected veteran’s vehicle as well as the safety of others driving on public roads and highways.

VII. Questions and Requests for Additional Information

All facts and information contained in this written statement are documented. To request additional information or documentation, please contact:

Dave Hubbard, CEO
National Mobility Equipment Dealers Association
3327 W. Bearss Avenue
Tampa, FL 33618
800-833-0427

VIII. Conclusion

Slow payment of VA invoices has been a matter of contention for NMEDA members since the Association was founded in 1989. While \$34 million may not seem like a lot of money to the federal government, it is an astronomical amount of money for the small business owners who are directly impacted by the VA’s payment process ineptitude. The inconsistency of policy administration appears to be getting worse and, in recent years, there has been no indication that VA Central Office has taken any meaningful steps to improve VA’s inability to promptly pay non-VA providers. It is obvious to us at NMEDA that complaining about regional or local slow payment inconsistencies to the Central Office only generates retaliation at the local level,

additional hardship, and loss of veteran business. NMEDA's work with the VA Prosthetics Department and the VBA to remedy the slow payment problem has only served as a band aid. Despite our best efforts, the problem of slow payment to non-VA providers has not improved, is not improving, and absent Congressional intervention seems unlikely to improve in the future.

While it costs the mobility dealer a substantial amount of money to invest the large sums of cash placed on hold with no interest added, NMEDA believes that the VA's inconsistent payment policies and procedures (as well as the agency's difficulties with other areas of business administration) are ultimately doing the greatest disservice to our nation's veterans. Mobility dealers are beginning to choose not to work with the VA, meaning our veterans' choice of qualified suppliers is becoming more and more limited. Automotive mobility products can be extremely complex and anything that could potentially limit the quality of service or the safety of an installation is putting the disabled veteran at risk, along with the general public with whom the veteran shares the road. We all know our veterans deserve better.

Respectfully Submitted,

Sam Cook
President
National Mobility Equipment Dealers Association

Dave Hubbard
CEO
National Mobility Equipment Dealers Association

PREPARED STATEMENT OF GENE MIGLIACCIO, DR.P.H.

Good morning, Chairman Benishek, Ranking Member Brownley, and Members of the Committee. Thank you for the opportunity to discuss the VA's reimbursement efforts for non-VA care providers. I am accompanied today by Mr. Joseph Enderle, Director, Purchased Care Operations.

VA provides care to Veterans directly in a VHA facility or indirectly through contracts, including contracts formed when providers accept individual authorizations, or through reimbursements, such as for emergency care. This mix of in-house and

VA Community Care provides Veterans the full continuum of health care services covered under our medical benefits package. VA's care in the community programs are designed to ensure high-quality care is provided effectively and efficiently to Veterans.

As Deputy Secretary Gibson remarked to the full House Committee on Veterans' Affairs at a hearing on May 13, 2015, VA understands the importance of complying with requirements of the "Prompt Payment Act" and making timely payments to community medical care providers. The organizational changes, implemented in Section 106 of the Veterans Access, Choice, and Accountability Act of 2014 (Veterans Choice Act), which consolidated payment of claims under centralized authority, serve as the basis for further improvements in making prompt payments.

Section 106 of the Veterans Choice Act required the Department to transfer authority to pay for health care furnished through VA Community providers and the associated budget to the Chief Business Office—Purchased Care (CBOPC) no later than October 1, 2014. VHA met this target and quickly re-aligned more than 2,000 positions and over \$5 billion dollars in health care funding to CBOPC from the Veterans Integrated Service Networks (VISN) and VA medical centers. This realignment established a single, unified shared services organization responsible for payment functions and centralized management allowing us to leverage business process efficiencies going forward.

VA has experienced tremendous growth in the volume of claims provided by community providers since implementation of the Accelerated Care Initiative which began on Wednesday, May 21, 2014. VHA has received 34 percent more claims from January 2015 through April 2015 compared to January 2014 through April 2014. Our current standard is to have at least 80 percent of our claims inventory under 30 days old. VHA staff makes every effort to ensure claims are processed timely. Processing timeliness is measured from the point the claim is received to when the claim is processed, and as a result, marked as complete. As of May 22, 2015, our nationwide performance was 72.50 percent, and if our metric was aligned with Medicare processing standards for other than "clean claims" (45 days), our performance would be at 76.15 percent. A "clean claim" is a claim that has no defect or impropriety, such as a coding error.

However, when claims without authorization are received from Community Providers, VHA reviews all authorities to ensure those claims are adjudicated based on the Veteran's eligibility. Claims received by VA without prior authorization is one significant factor in the delay of claims processing.

Information on community care is available to Veterans on the VA website as well as the Federal Benefits for Veterans, Dependents, and Survivors booklet. Based on regulatory and statutory authority, all Veterans are not eligible for community care in all situations. An example would be when a claim is received for a non-service connected Veteran who also is not enrolled in VA care. When claims are denied, Veterans are notified timely along with their right to appeal. As detailed later in the testimony, VHA staff are also reaching out to Community Providers and providing resources to educate them on Veteran eligibility and timely notification requirements.

Improvement Strategies

VA acknowledges that claims processing timeliness must improve. As a result, we are in the process of refining and implementing standard processes and performance targets, and monitoring to ensure processing activities are performed and measured consistently across VA. This will enable us to deliver exceptional customer service to Veterans and Community Providers.

In an effort to better process claims, CBOPC established the Support Claims Processing Division (SCPD) in March 2015. The SCPD was established in the Denver location to assist with processing claims when sites have high turnover, when sites receive a sudden increase of claims, and to assist with verification of claims. To address the increasing inventory and work the growing backlog, CBOPC identified a need to add more staff to SCPD in Denver. However, available space was not sufficient to add additional staff, so SCPD established a second shift to better utilize existing space. VHA is currently in the process of implementing second shifts at other

claims processing centers across the country. The new shift has the benefit to VHA of opening recruitment to a pool of candidates seeking to work non-traditional hours for the Federal Government.

Additionally, CBOPC established a contract to add offsite contract staff support to process claims at those sites which have significant claims inventories. The first task order was issued in May 2015 to provide claims processing staff support to process 400,000 invoices, with a projection to increase processing to 600,000 claims by the end of this fiscal year. Currently, 145 full-time employees and contractors are onboard at SCPD. Over 40 more should be added by the end of June 2015, with additional staff projected to be added to a night shift by the end of September 2015. VHA continues to explore ways to add resources to better comply with the Prompt Payment Act and ensure that our community partners are well situated to continue providing care to our Nation's Veterans. In compliance with the Veterans Choice Act, approximately 2,000 positions were transferred from VISNs and VA medical centers to the VHA CBOPC. VHA has advertised positions for claims processing at over 75 different geographical locations and plan to hire up to an additional 220 full-time employees. We are also advertising an open-continuous Merit Promotion Announcement for Voucher Examiners to include targeting special appointment candidates.

Currently, VHA is implementing technical fixes and process changes for issues preventing claims from being processed in a timely manner. All community care referrals require authorization. To obtain authorization in an emergency care situation, a Veteran should contact the closest VA medical center within 72 hours of admission to community care. Without the authorization, claims cannot be processed delaying payment processing. In some cases, authorizations are not entered timely in the VA payment system due to the administrative process. This is a processing issue we realize we must resolve. To address those situations, we are working with non-VA Care Coordination Staff to ensure authorizations are entered before a claim is received.

Many community providers submit duplicate claims, due to the fact that their original claim was not paid in a timely manner. In an effort to identify duplicate claims within the payment processing system, software scripts were developed to identify the duplicates which will reject duplicate claims, leaving the oldest claim in inventory for processing.

VHA is continuing to find ways to improve our systems. Currently, we are working with the VA Center for Applied Systems Engineering to standardize business processing to increase efficiencies and reduce variation using Lean methodology. Starting in July 2015, testing of the standardized business processing will take place in VISN 19. National employee performance standards are being developed to improve accountability and performance. Lastly, a Centralized Call Center Pilot is underway in VISN 16, with calls being answered by CBOPC staff in Denver. This pilot has dramatically reduced customer service wait times and abandonment rates. We have also completed technical site visits to evaluate how well the current software design is meeting business needs in order to implement corrective actions.

Another important aspect is our improved outreach efforts with stakeholders. We are finding better and more frequent ways to communicate the status of claims processing timeliness with non-VA care providers, Members of Congress, and Veterans. Ongoing training is being provided to community providers on the resources available to address the provider accounts receivables reports, to include monthly calls held with providers on account claim concerns. Later this year, we hope to begin distributing quarterly bulletins to providers on claims processing changes and issues. A future project could include developing a claims status portal for providers to access claims status information. Call Center staff will receive refresher training to address unique community provider issues.

Process Improvement Results

Our recent actions have had a significant impact in processing volume. From January 2015 to May 2015, VHA processed 5,988,117 claims, a 21-percent increase from the 4,946,989 claims processed from January 2014 to May 2014.

VISN 16 is a strong example of improvement based on our recent actions. In December 2014, 35.58 percent of claims were paid in under 30 days. In May 2015, 82.13 percent of claims were paid in under 30 days. At the facility level, in May 2015, 83.13 percent of claims in the Southeast Louisiana Veterans Health Care System's inventory were paid in under 30 days. This is a significant improvement from the 35.29 percent in December 2014.

Conclusion

In conclusion, VA strongly values its relationship with our community providers. We realize the vital role they play in assisting us in providing timely and high-quality

ity care to Veterans. We are working hard to expedite payments and streamline our claims services in order to make this an effective and efficient process for all.

Mr. Chairman, I appreciate the opportunity to appear before you today. We are prepared to answer any questions you or other Members of the Committee may have.

Testimony of the Honorable Charles W. Boustany, Jr., M.D.
 Hearing of the House Veterans' Affairs Subcommittee on Health: *Assessing the VA's Ability to Promptly Pay Non-VA Providers*

June 3, 2015

Chairman Benishek, Ranking Member Brownley and Subcommittee Members:

Thank you for providing me the opportunity to submit written testimony to the Subcommittee for this important hearing. It is of vital importance that Congress seeks solutions to the problem of delayed payments within the Department of Veterans Affairs (VA).

For years, Louisiana veterans have been subject to the VA's inability to timely and properly process and pay claims. The VA has proved particularly negligent with regard to claims for emergency medical services rendered by non-VA providers. As you know, veterans may end up liable for the cost of these emergency services when the VA refuses to process and pay their claims. Pursuant to P.L. 113-146, the Veterans Access, Choice, and Accountability Act (VACAA) of 2014, the Veterans Health Administration's Chief Business Office Purchased Care (CBOPC) was placed in charge of claims processing for emergency medical services. Prior to VACAA becoming law, this responsibility rested at the Veterans Integrated Service Network (VISN) level. Because claims were processed at each of the 21 VISNs individually, there were staggering differences in claims processing rates around the nation. In transferring claims processing authority to a centralized system, VACAA demanded the VA improve its performance in this area.

Before VACAA's passage, VISN 16, the network that oversees health care for veterans in Louisiana, Mississippi, Arkansas, Oklahoma and portions of several other states, admitted to years of inappropriate practices including denying veterans' claims for false reasons such as "not timely filing of medical records" when providers had sent those records to the VA via certified mail. A team of senior VA staff was sent to VISN 16 to further investigate, and it was also discovered that VISN 16 staff had written hundreds of thousands of letters to veterans and providers, but had simply never sent those letters to their intended recipients. This behavior is inappropriate and unacceptable. Members of the investigatory team sent to VISN 16 are current CBOPC staff, and I was hopeful that after seeing firsthand what Louisiana veterans were dealing with, the CBOPC would make it a priority to improve the VA's claims processing practices.

In March, I requested information on the current state of the backlog of emergency medical service claims from the CBOPC. The information I received is extremely disappointing. For claims originating out of VISN 16, the VA reported processing only 14% of claims within 30 days. Timely processing rates in some other parts of the country are even worse.

Moreover, when my office asked the CBOPC if they could provide data on the percent of inappropriately denied claims that were overturned to be re-adjudicated, we were told the CBOPC is "not able to provide data pertaining to that question. Information regarding clinical appeals and overturned denials is not available in our data sets." The VA repeatedly states they are committed to clearing the backlog and improving claims processing operations, but how can they begin to rectify these issues if they are not keeping track of the veterans they have wronged?

One veteran in my district, Mr. Al Theriot, waited more than two years to see his emergency room and ambulance bills paid. The VA only contacted him after he went on television twice and Senator

Vitter and I wrote the VA secretary demanding an explanation. The VA lost his medical records twice without apology. Mr. Theriot's claim has since been resolved; however no veteran should have to appear on television to force the VA to do its job. He and thousands of other veterans deserve better customer service after risking their lives for our freedom and safety.

As mentioned earlier, the VA states in many cases such as Mr. Theriot's that they have not received the medical records necessary to process a claim, and subsequently denies that claim under the classification of "not timely filing of medical records." Because the VA does not allow electronic submission of medical records, providers had no way of proving the documents were actually being sent. As such, many providers resorted to sending the records by certified mail to confirm receipt by the VA. However in some instances, the VA continues to deny records were received.

This raises the disturbing question: When a health care provider is able to demonstrate via certified mail that required medical records were received by the VA, yet the VA denies receiving them, what has happened to those records? It seems highly unlikely that hundreds of certified mail carriers are repeatedly losing these documents. After being delivered to the VA, are the records filed away, never to be scanned and processed for review? Are they thrown away or shredded? How can the VA guarantee these records have not fallen into the wrong hands if they claim the documents were never received despite providers having proof they were? Medical records contain personal health information, and each time these documents are "lost," a veteran's privacy is being compromised.

If VA employees are refusing to scan and process medical records received, Congress must consider punishing bad actors, modernizing equipment to allow providers to send electronic records or allowing the VA to contract with a third party to carry out claims processing.

Attached to my testimony, you will find detailed information from two, of the many, Louisiana hospitals that struggle to collect payment from the VA for services rendered to our veterans. You will also find the information sent to my office by the VA regarding the status of the backlog as of March 26, 2015. The data shows a nationwide backlog of more than \$878 million for non-VA emergency medical claims. This is absolutely unacceptable.

Louisiana veterans should not have to fear a trip to the emergency room will plunge them into unsustainable debt, nor should they fear that the VA is mishandling their private medical records and compromising their personal information. The VA must end the inappropriate practices that have led to this unacceptable backlog, and commit to improving their claims processing performance. Our veterans deserve nothing less than the highest quality of care and customer service possible, and I thank the Subcommittee for its efforts to resolve these issues.



House Committee on Veterans' Affairs
Subcommittee on Health

Assessing VA's Ability to Promptly Pay Non-VA Providers

Written Testimony for the Record
Ernie Sadau, Chief Executive Officer
CHRISTUS Health

June 3, 2015

CHRISTUS Health is an international, faith-based, not-for-profit health system comprised of nearly 350 services and facilities, including more than 50 hospitals, primarily located in Texas, Louisiana, and New Mexico. We applaud the Subcommittee for examining the Department of Veterans Affairs' (VA's) ability to promptly pay non-VA providers for health care services provided to veterans.

As a mission-driven organization, CHRISTUS Health strives to provide high quality services and to create healthy communities for the patients we serve. Part of our vision is to increase access to care, and CHRISTUS Health is one of the largest providers of uncompensated care among Catholic-related health systems. To advance our mission, it is extremely important to obtain reimbursement from government payers for services provided in a timely manner.

Numerous CHRISTUS hospital facilities have proudly provided emergency services to veterans in the communities we serve. Most of these claims are for non-service related treatment and qualify for payment by the VA under federal law. CHRISTUS has subsequently and correctly billed the corresponding Veterans Integrated Service Network (VISN) for payment. All services provided in central and south Texas have been billed to VISN 17, located in Bonham, Texas. All services provided in north Texas, southeast Texas, and Louisiana have been billed to VISN 16, located in Flowood, Mississippi.

Our repeated attempts to collect payments through VISNs 16 and 17 have required significant staff efforts at additional administrative cost. To date, approximately 3,122 outstanding and unpaid claims remain, totaling \$5,491,600.76. CHRISTUS Health respectfully requests the Subcommittee's assistance in directing the VA to expedite reimbursement for all outstanding claims properly submitted for payment by non-VA providers.

Through its experience as a non-VA provider, CHRISTUS Health has identified the following issues that make collecting payment from the VA particularly time and labor-intensive: (1) extended wait times and non-responsiveness by VA staff; and (2) excessive claims processing times.

I. Extended Wait Times and Lack of Staff Response

CHRISTUS Health's claims collection staff have experienced excessive hold times of between one to four hours. Once a CHRISTUS staff member is able to speak to VA staff regarding outstanding and unpaid claims, the VISN limits its response to a maximum of four accounts during particularly busy times. On several occasions, VA staff members have instructed CHRISTUS to fax a list of outstanding claims to obtain information regarding the status of these claims.

On occasions, several VA staff members have offered to provide assistance in ensuring timely reimbursement



for unpaid claims. After reaching out by fax or to a specific VA staff person, however, CHRISTUS Health has been unable to obtain a status update or payment of outstanding claims. Once a claim is submitted, if CHRISTUS is able to obtain an update on the claim's status, VA staff report only that the claim is being reviewed. This status is typically communicated at each request for an update, prolonging the delays in claims processing.

II. Excessive Claims Processing Times

Reimbursement is delayed by the VISN through various means. For example, CHRISTUS Health has had difficulty in confirming that medical records information was timely received even though we have proof of delivery by certified mail. If the VISN reports that it has not received the claim, we send the claim a second time and sometimes a third time by certified mail.

When CHRISTUS Health provides the VISN staff with the certified tracking number for a claim, often the staff will report that although the VA received the claim, it has not been scanned and uploaded to the VISN's system. We have found that the time between when the VISN receives the claim and uploads it into its system can be several weeks. Claims that VISN staff acknowledge as received and complete with the associated documentation are sometimes delayed for medical review, which also takes several weeks.

CHRISTUS Health routinely provides the VISN with the complete medical record associated with a claim. However, the VA commonly requests that CHRISTUS Health provide a specific document from the medical record (*i.e.*, progress notes, nurse notes, emergency room summary). This request prolongs the payment cycle despite the fact that the documentation was provided as part of the medical record that was sent by certified mail to the VISN. We also have experienced difficulty in obtaining information on our accounts for various reasons such as patient names that are missing a middle initial. Finally, VA representatives have confided to CHRISTUS Health that the VA has a backlog of unpaid claims, and insufficient staffing results in delays in claims processing.

In conclusion, CHRISTUS Health remains deeply committed to serving veterans as a non-VA health care provider. We simply cannot afford the continuing burden of delayed and unpaid claims that were properly submitted to the VA for payment, however. We therefore respectfully request the Subcommittee's continued and active oversight to ensure that the VA resolves the backlog of overdue claims in a timely manner. Thank you again for your leadership on these issues and your consideration of our views.

OUR MISSION "To Extend the Healing Ministry of Jesus Christ"

CHRISTUS Health
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Tel: 469.282.2000
www.christushealth.org



May 14, 2015

The Honorable Charles Boustany, MD
United States House of Representatives
One Lakeshore Drive, Ste # 1775
Lake Charles, LA 70629

Dear Congressman Boustany,

In response to your inquiry regarding our hospital's challenge in working with the VA, please accept the following:

Lake Charles Memorial Hospital (LCMH) has outsourced the billing and collection of VA claims to Alegis Revenue Group, LLC (Alegis) as a result of the difficulties in collecting amounts due from the VA. Alegis currently handles the VA claims for 36 Non-VA facilities, covering 7 states in 6 different VA Regions (VISN5, VISN 8, VISN 9, VISN 16, VISN 17, and VISN 18). According to Alegis, the cost in managing this VA inventory has been three times or greater than the cost to manage other payer inventories. Additionally, many of the issues presented below with regard to the VISN16 claims processing are present in the other VISN claim processing units. LCMH received the following synopsis from Alegis and at the present time is willing to share this information with you.

Everything Your Healthcare Should Be.

1701 Oak Park Boulevard

Lake Charles, Louisiana 70601

phone: 337.494.3000

fax: 337.477.6938

www.lcmh.com

Below is the current summary of Lake Charles Memorial Hospital's VA inventory broken out by claim year:

Unresolved Claims

| Claim Year | Category | Count of Claims | Estimated Reimbursement | Percent of Claims |
|--------------------|--------------------------|-----------------|-------------------------|-------------------|
| 2012 | Final Denial | 4 | \$ 45,861.51 | 40.00% |
| | PAID | 5 | \$ 22,315.30 | 50.00% |
| | Unresolved Claims | 1 | \$ 1,238.21 | 10.00% |
| 2012 Total | | 10 | \$ 69,415.02 | |
| 2013 | Final Denial | 61 | \$ 127,336.47 | 29.05% |
| | PAID | 113 | \$ 380,090.87 | 53.81% |
| | Unresolved Claims | 36 | \$ 50,704.51 | 17.14% |
| 2013 Total | | 210 | \$ 558,131.85 | |
| 2014 | Final Denial | 101 | \$ 120,801.60 | 16.92% |
| | PAID | 255 | \$ 706,702.40 | 42.71% |
| | Unresolved Claims | 241 | \$ 375,661.73 | 40.37% |
| 2014 Total | | 597 | \$ 1,203,165.73 | |
| 2015 | Final Denial | 7 | \$ 5,517.60 | 4.35% |
| | PAID | 27 | \$ 67,132.17 | 16.77% |
| | Unresolved Claims | 127 | \$ 307,518.65 | 78.88% |
| 2015 Total | | 161 | \$ 380,168.42 | |
| Grand Total | Unresolved Claims | 405 | \$ 735,123.10 | |

Highlighted in yellow are the "Unresolved Claims" that are still pending adjudication/resolution from the VA. The claims from 2014 and older have been billed, re-billed, resubmitted, and reconsiderations filed multiple times to no avail. All initial billing done by Alegis is done electronic and a red & white Uniform Billing form (UB) is also printed and bundled with all supporting documentation and mailed via certified mail to the appropriate VA claims processing unit. Alegis tracks and confirms delivery of all submissions to prevent any delays as well as prevent denials for missing medical records or no claim on file. According to Alegis however, 66% of the claims delays are for the following reasons that fall on the Central Fee Unit (CFU) side of the process:

- Alegis has not been able to locate where the Preliminary Fee Remittance Advice Report (aka PFRAR or PFAR) letters (which provide the adjudication of submitted claims) are being sent or if they are in fact being sent to determine the ultimate resolution of the claim. There does not appear to be an electronic methodology of obtaining PFAR letters.
- Medical Records processing is still causing erroneous Electronic Data Interchange (EDI) claims rejections and claims delays. Alegis has shown the Veterans Integrated Service Network (VISN) proof of timely submission via Certified Mail

of records delivered to the CFU yet the EDI claims are rejected and closed. Apparently, the submitted red & white UB claim form that is sent along with the supporting documentation is also not being scanned into any archive at all.

- “Claim Not on File” denials continue despite our proof of paper billing via Certified Mail. Possible scanning delays or issues at the CFU may be the issue here. It is our understanding that this may also be partially caused by CFU staff who have the ability to delete claims out of the system.
- “EDI Re-Route” rejection issues generating from the initial claim verification process are causing processing delays from the start. The assignment of a claim to a VA Medical Center (VAMC) is based on the patient’s zip code listed on the claim. Alegis confirmed with VISN 16 that the zip codes on several claims with this rejection reason actually do belong to the VAMC that the VISN is having to re-route the claims to and not the VAMC that the EDI process assigns them to. Alegis recommended to the VISN 16 that these Re-Routing issues should be escalated to the Fee Basis Claims System (FBCS) personnel who handle these types of issues to be researched and resolved to prevent future re-route issues and delays.
- Many of the claims on our claims status spreadsheets end up with a status of “Approved; Reopen claim and sent for processing”. This is a clear indication that the FBCS and the CFU staff are likely causing erroneous or premature rejections/denials.

Overall, the communication and responsiveness from VISN16 has improved significantly over the last 5 months. They are also more willing to assist on getting problems not only identified, but also corrected. Although this represents great progress in communication, VISN16 has not produced a significant improvement in aged claims resolution or cash flow for LCMH.

There apparently remains significant staffing shortages at VISN16 that continue to delay the resolution of claims (payments or final denials), and in particular, each VISN lacks adequate staff to review and adjudicate Requests for Reconsideration.

Sincerely,

Larry M. Graham
President & CEO
Lake Charles Memorial

| VISN | Total number of emergency medical claims and billed charges | | Total number of claims and billed charges aged greater than 30 days | | Number of veterans with unpaid claims under consideration in each VISN | Percent of clean claims processed within 30 days |
|--------------------|---|---|---|---|--|--|
| | Total Number of Emergency Medical Claims | Total Billed Charges for Emergency Medical Claims | Emergency Medical Claims > 30 days | Billed Charges for Emergency Medical Claims > 30 days | | |
| 1 | 23,346 | \$36,587,417.07 | 10,436 | \$13,249,858.71 | 8,527 | 42.79% |
| 2 | 11,717 | \$16,397,053.66 | 6,725 | \$8,314,542.11 | 3,999 | 22.95% |
| 3 | 14,794 | \$47,893,707.12 | 10,712 | \$29,838,755.47 | 6,502 | 30.06% |
| 4 | 6,778 | \$23,195,965.26 | 493 | \$3,238,480.66 | 2,117 | 57.95% |
| 5 | 5,977 | \$16,470,563.21 | 2,401 | \$7,449,338.33 | 2,638 | 51.88% |
| 6 | 93,828 | \$252,088,580.38 | 48,402 | \$136,466,191.33 | 34,411 | 12.15% |
| 7 | 49,414 | \$148,933,196.91 | 20,891 | \$71,376,042.32 | 17,158 | 23.16% |
| 8 | 52,404 | \$188,068,231.59 | 16,885 | \$81,325,272.49 | 14,950 | 39.22% |
| 9 | 16,662 | \$41,994,851.64 | 6,013 | \$15,076,379.48 | 6,317 | 39.72% |
| 10 | 59,757 | \$151,777,547.70 | 31,205 | \$77,119,429.13 | 21,794 | 7.98% |
| 11 | 24,267 | \$55,423,325.02 | 8,680 | \$26,142,162.61 | 7,931 | 29.70% |
| 12 | 23,107 | \$77,782,241.89 | 12,199 | \$38,518,323.13 | 8,132 | 34.85% |
| 15 | 13,385 | \$37,484,896.97 | 4,070 | \$11,262,837.22 | 4,419 | 48.30% |
| 16 | 50,281 | \$155,558,769.02 | 18,465 | \$78,353,326.77 | 18,338 | 14.03% |
| 17 | 45,696 | \$174,730,041.57 | 26,126 | \$97,496,059.01 | 15,331 | 9.98% |
| 18 | 45,489 | \$117,236,797.11 | 14,513 | \$39,755,652.70 | 13,083 | 19.55% |
| 19 | 54,666 | \$95,211,795.30 | 5,086 | \$10,748,061.83 | 15,111 | 17.86% |
| 20 | 46,007 | \$113,471,754.30 | 21,326 | \$50,487,299.69 | 14,167 | 18.95% |
| 21 | 36,609 | \$105,845,931.45 | 22,306 | \$64,241,788.95 | 14,488 | 24.68% |
| 22 | 17,634 | \$59,549,252.05 | 2,475 | \$11,103,339.07 | 5,673 | 61.62% |
| 23 | 16,659 | \$42,786,940.14 | 3,603 | \$7,061,626.63 | 5,261 | 38.38% |
| Grand Total | 708,477 | \$1,958,488,859.36 | 293,012 | \$878,624,767.64 | 240,350 | |

Emergency Medical Claims are claims designated as Mill Bill, Unauthorized or SC Emergency.

| Program | # of Claims | Billed Charges | % of Total |
|--------------|-------------|--------------------|------------|
| Authorized | 607,319 | \$1,489,312,538.05 | 37.27% |
| Mill Bill | 331,245 | \$968,756,888.44 | 20.33% |
| SC Emergency | 32,740 | \$66,370,681.38 | 2.01% |
| Unauthorized | 344,492 | \$923,361,289.54 | 21.14% |
| Unknown | 313,824 | \$378,068,458.12 | 19.26% |
| Grand Total | 1,629,620 | \$3,825,869,855.53 | |

Data Sources: FY 15 Central Fee payment files
 FBCS ClaimsNotProcessed file
 Inventory data is as of 3/26/15

Written Testimony**Submitted by**

**Debora M. Gault, National Vice President of Federal Reimbursements & Regulatory Affairs
American Medical Response**

Committee on Veterans Affairs**Subcommittee on Health****U.S. House of Representatives****Assessing VA's Ability to Promptly Pay Non-VA Providers**

June 3, 2015

American Medical Response (AMR) is honored to have this opportunity to submit a written statement to the House Committee on Veterans Affairs' Subcommittee on Health for the hearing on June 3, 2015, entitled "Assessing VA's Ability to Promptly Pay Non-VA Providers." AMR is the nation's largest single ambulance provider with operations in over 2100 communities within 40 States; serving our nation's veterans in every one of our operations. AMR proudly serves our nation's veterans on both an emergency basis, through 911 calls, and a non-emergency basis through contracts with the Department of Veterans Affairs (VA). Like so many other non-VA providers in the country, AMR has had consistent difficulty getting reimbursed by the VA for services we provide to veterans. The current payment backlog at the VA for AMR claims currently totals approximately \$12 million. AMR has been working diligently with the VA for over a year to try to get the backlog resolved. Unfortunately, there has been very little progress. We believe our experience will provide some insight to the Subcommittee as they examine the issue of prompt pay at the VA.

Background

AMR has been operating since 1992 and currently provides over 3.3 million transports annually to patients in the communities we serve. Approximately 100,000 of these services are provided to veterans across the nation. AMR has over 19,000 employees nationally and many of them are veterans. We have been diligent in our recruiting efforts to attempt to reach and provide employment to as many veterans as possible and have established recruiting and training programs to provide a career path within AMR for our military heroes who are returning to civilian life. Our objective is for every veteran who desires a career in the world of Emergency Medical Service to be able to attain their goal.

Each of AMR's operations provides clinical ambulance services to our nation's veterans. As a result, AMR works directly with 20 of the VA's Veteran Integrated Service Networks (VISN) when submitting claims and the required documentation as we attempt to secure reimbursement for our services. Unfortunately, as we stated previously, this is not an easy task. While we do everything possible to ensure that veterans' covered services are paid directly by the VA with as little involvement by the veteran as possible, the VA's current lack of consistent processes at the VISN level and the huge problem of inadequate resources to adjudicate submitted claims make this goal extremely difficult, if not impossible.

VA is Delinquent in Payment for both Emergency and Non-emergency Claims

While ambulance services for veterans are virtually all provided by non-VA service providers and are fairly straightforward on the aggregate, attempting to follow the claims processes and regulations put in place by the VA is extremely complicated.

Most non-emergency ambulance services are prior authorized through contractual relationships directly with area VA facilities and claims submission and payment criteria are spelled out within written agreements. Even with these requirements in place, AMR currently has over \$500,000 of contracted claims that are over 90 days old. If we apply the prompt payment regulation, which requires contracted claims to be paid within 30 days, and interest calculation, this amount due increases to over \$2 Million. These are all services that were both prior authorized and requested directly by the local VA facility. As you can imagine, it is frustrating to us that we have abided by our agreements with the VA and have provided contractually obligated services, while the VA has not followed through with its responsibility to provide timely payment.

Emergency or 911 ambulance services are provided by law to patients that require treatment and transport to the hospital when a request for an ambulance response is received within the service area's call center. The request is received from the patient, a family member, a bystander or medical facility personnel. Using nationally standard clinical dispatch protocols, based upon the information provided by the requesting party, ambulance services must send their resources without the ability to observe the actual condition of the patient at the scene until they arrive. Because of the uniqueness of this scenario, payers universally recognize the "Prudent Layperson Standard" for reimbursement to ambulance services. Basically, if an individual without any prior medical training or education perceives that the patient is in need of medical assistance as quickly as possible and that an ambulance should be requested, and if the ambulance service can provide the appropriate documentation that proves this scenario occurred, the emergency response and the level of service required to treat the patient's condition described at the time of the request is reimbursable. While the VA regulations clearly state that their payment policies follow this standard as well, as we'll discuss in more detail later in the testimony, this is not VA practice. Due to the VA's mishandling of emergency claims, the backlog of emergency claims for AMR at the VA totals over \$7.5 million.

We have provided information regarding the claims backlog that AMR has at the VA to the Subcommittee. The claims are categorized by contracted services and non-contracted services and also by age of the claim. We are also able to break this information down by VISN. The data show the bulk of the AMR's outstanding claims have been backlogged at the VA for well over 30 days. 30 percent of our emergency claims and 13 percent of our contracted claims are over 90 days past due. Some claims have been outstanding for as long as over a year. We have provided this, and other information, to the VA at their request and would be happy to answer any questions the Subcommittee may have about the data.

Discussions with the VA have not Resulted in Resolution

Receiving prompt payment from the VA has been an ongoing problem for years. However, as we indicated above, clearly the problem has begun to reach critical mass. AMR has established and nurtured relationships with management level personnel at each of the VISNs we interact with, however, over many years, we have seen little or no progress toward any type of consistent resolution. A year ago, when we had tried everything we could think of to resolve the problem internally, AMR reached out to Congressman Mike Coffman (R-CO), the Member of Congress for AMR's headquarters in Greenwood Village, Colorado and a member of this Subcommittee. Through Congressman Coffman's assistance, AMR began attending weekly conference calls with representatives of VA management from the Central Business Office (CBO) who oversee VA transportation benefits to discuss the delays in processing our claims. These calls are still ongoing today.

We have also received contact information for each of the VISNs, so that we can deal with them directly. We have been working with each of the contacts provided to us but none have been able to produce consistent solutions and resolve the payment issues that have caused the current backlogs. AMR has been asked to schedule weekly calls with several of the VISN management and we have done so, only to sit on the calls at the scheduled times without any participation whatsoever from the local VISN. This is a regular occurrence. While we continue to try everything at our disposal to work directly with the VISNs to address and resolve the problems and the payment backlog, we do not see any sense of urgency on the part of the VA personnel to truly address the issue.

In August 2014, representatives of the VA CBO agreed to meet with AMR and our colleagues from Acadian Ambulance based in Louisiana in person at their Atlanta facility. Most of the VISN managers AMR and Acadian interact with also participated in this meeting by phone. At the meeting in Atlanta, AMR worked with the VA to identify the problems the VA encounters during claims processing. We also made several recommendations for resolving these issues and streamlining claims processing overall. The VA did not follow up on our recommendations or offers of collaboration and the problem of outstanding claims has continued to grow.

Several Problems Contribute to VA's Delinquency in Claims Processing

As a result of our discussions with the VA, AMR has been successful in identifying several problems that we believe are contributing to the claims backlog at the VA.

VISNs Claim Lack of Funding

When AMR discusses the backlog of claims with the individual VISNs, we are often told that they are out of funds appropriated for ambulance services in their budgets, and we will have to wait until the next fiscal year to be paid for our claim. This can occur as early as the first quarter of the year and would require us to wait until after October 1 of that year, or even the following year in some cases, to obtain payment for our services. When AMR raised this issue at the meeting in Atlanta, VA management personnel from the VA CBO were actually surprised to hear about it, but the VISN participants admitted that they budget for ambulance usage based upon prior year volumes. AMR pointed out that if this was

the methodology they used annually to budget for outgoing years, the cycle of under-budgeting would continue, especially if the previous year's claims were still unpaid. The VA CBO personnel informed the VISNs that there were sufficient funds at the national level and if they required additional funding to pay for the ambulance claims they had received, they should contact the CBO and funds would be released immediately to allow the claims to be paid. This apparently did not occur as we continue to hear unavailable funds as a reason claims cannot be paid.

AMR offered our resources to review the VA's budgeted data annually to assist them with getting as accurate of an estimate as possible for the following year's payment requirements. While the CBO personnel agreed it would be beneficial to work in partnership with the industry when the budgeting process occurred this year, this has not transpired, despite reminders and outreach from AMR to the VA. Unless the budgeting process is addressed, the VISNs will continue to improperly calculate the amount of funding necessary for ambulance services in a given year.

Electronic Claims Transmission is not Available for Submission of All Ambulance Claims

At the VA, Electronic Claims Transmission (ECT) is not available for ambulance claims submission for most services provided to veterans. At the time of our meeting in Atlanta, most VISNs had not repaired a problem that was prohibiting most ambulance services (including AMR) from submitting even contracted, prior authorized claims via ECT. This problem has since been rectified and contracted claims can be submitted via the OB-10 format. Emergency ambulance claims created a much more complicated process. The claim must be designated as a non-VA provider situation and then separated into a service or non-service related transport prior to processing. AMR's Las Vegas operation has been working directly with the Information Technology team at the VA to attempt to develop an ECT process for submission of these claims. Through the diligent efforts of our AMR team, significant progress has been made in this area and we recently have submitted some test batches of claims through a third-party claims processing intermediary to the VA. We hope to learn that all problems and bugs are worked through and that this option will be released to the ambulance industry at large very soon.

VA is Requiring External Records from other Health Care Providers before Paying Emergency Claims

As we discussed briefly earlier in the testimony, the VA is holding emergency ambulance claims prior to processing or payment until medical records are received for the veteran's entire episode of care on the day of the ambulance transport. Even if the veteran meets the additional requirements established within the VA's payment regulations (e.g., whether the incident is service or non-service related, whether the patient has been seen within a specified period of time prior to the current date of service), the VA does not truly utilize the prudent layperson standard to establish payment for emergency medical services. In addition to the ambulance service's documentation, the VA claims that it also requires documentation from all other medical providers that are involved with the patient's care on the date in question before the VA can pay any of the claims received. Putting these criteria in the ambulance service's context, the ambulance provider's claim cannot be reimbursed until all medical records from the hospital and other clinicians that see the veteran on the day of their ambulance transport are received and reviewed by the VISN. This means that even though the ambulance service

personnel are not even present and the ambulance service has absolutely nothing to do with the care that is rendered once the patient is transferred to the receiving facility, the ambulance provider's claim is delayed until all other claims are received and evaluated to determine whether the entire incident can satisfy the need for medical care on that date.

For example, the ambulance service may be told that a patient with chest pain requires an ambulance response. The paramedics arrive on scene and after assessing the patient and evaluation of an EKG and other medical treatments they utilize on scene, they establish that the patient is complaining of chest pain and treat the patient as such. Upon arrival at the hospital, the patient then receives further assessment and diagnostic testing and the final diagnosis is an anxiety reaction or possible heartburn or epigastric pain. After reviewing the hospital records (which the ambulance service neither has control over or is privy to the patient's treatment after their clinical service to the patient has been completed), the VA determines that the patient's episode of care that day does not meet medical necessity standards and all claims for payment should be denied. This is a very common scenario and while we appeal these claims on a standard basis, the VA continues to merge the ambulance claim into the care rendered after the ambulance service is no longer even involved with the patient when determining whether the veteran's episode of care should be paid. If VA regulations state that the Prudent Layperson is the standard by which the VA will reimburse emergency medical services, then that is the standard that should be used. Unfortunately, that is not the case.

Recently, Congressman Coffman contacted the VA about this issue on our behalf. Acadian Ambulance also asked Congressman Boustany (R-LA) to write to the VA regarding this issue. It is our understanding that in the response that Congressman Boustany received from the VA, the VA stated: "... VA does not require an ambulance provider to submit all clinical notes related to the emergent episode of care. In response to your constituent's comment that it does not need to submit medical documentation from the receiving facility, we agree that emergency transportation claims typically only include the ambulance company's notes related to the transport of the eligible Veteran to the non-VA emergency facility." While we appreciate that the VA agrees with our interpretation of the requirements for documentation, in practice VISNs are requiring ambulance companies to submit this external documentation. As a result, ambulance claims are delayed and many are ultimately erroneously denied.

There are not Enough Resources within the VISNs to Process Ambulance Claims

Another problem discussed openly at the August meeting is that there are not enough resources within the VISNs to process ambulance claims. The VISNs were actually very honest that this is absolutely true. We are always told by VISN personnel that the reason there is such a backlog of our claims is that they simply do not have enough people working on them. We also discussed the fact that when one of the dedicated personnel at the VISN is not working for a period of time, there is no process to accommodate any backfill of that person's work. So, they leave a backlog when they go on vacation or medical/personal leave and come back to a backlog that is exponentially worse because no one has been processing any of these claims in the meantime. The VA CBO stated that they would discuss this problem with the management level personnel on their monthly VISN call and report back with a

solution. This has never occurred and we continue to face the problem that there are never enough VISN employees to process the volume of ambulance claims that are regularly submitted.

The VA 30 Day Timely Filing Timeframe for Claims is Totally Inadequate

Respectfully, we believe the VA 30 day timely filing deadline for claims is unworkable. Ambulance services are only with the patient for a very short time and often in situations where they can obtain very little information about the patient or their insurance coverage. As a result, much of the patient information must be obtained after the patient leaves our direct care. We often hear from the patient after they receive their invoice or even the second invoice notice that they are veterans which is often already past the 30 day claims filing requirement. Because of the uniqueness of our service, it is sometimes impossible to discuss potential third party coverage with our patients and family members. Expecting a 30 day turnaround on emergency ambulance claims is truly not reasonable. While we try as hard as possible to meet that deadline, we must often rely on the veteran after the date our service was rendered to contact us to let us know that we should be submitting a claim to the VA. If the veteran is in the hospital for any length of time after our service is rendered, the situation is exacerbated as a request for third party insurance coverage notice is most likely waiting at home for them when they are discharged. While the veteran may contact us as quickly as they can, often they are too late to allow us to meet the unreasonable 30 day filing requirement.

The problem we described above regarding the VISN waiting to obtain all medical records for the episode of care before they will pay the ambulance claim is also causing denials for untimely filing which often results in the veteran becoming financially responsible. If the VISN receives the ambulance claim timely, staff will still state that they require the other provider medical records which may not come at all, or they may be received well after the filing deadline has past. Because the VISN considers these external medical records as a part of the "incident" and must have all of them to consider making payment, the timely filing deadline requirement is often missed due to no fault of the ambulance provider at all.

We have also found that despite the fact that we file manual claims within the 30 day filing deadline and we send the claims via certified mail so that we can be certain to have proof that the claims were received timely, the VISN will state that they either never received our claim (even with the signed receipt) or the claim was not received within the filing deadline. We must then appeal the decision with the VISN. The appeal process is a very tedious and long process. Even with the proof of receipt, we often receive "untimely filing" denials as the VA's final decision.

When VA does not Pay Claims, Veterans are Affected

When the VA does not pay claims, veterans can be held responsible. AMR does everything possible to hold claims until they receive notification directly from the VA that the claim is either not covered or is paid. As you can see on the data we have provided, there are claims that are over a year old that we are holding as we are hoping that we do not have to hold the veteran financially responsible if the VA should cover their service. We will notify the veteran in the revenue billing cycle that we are submitting their claim to the VA for payment and request their help in trying to resolve the debt by asking them to reach

out to the VA personally, but if there is any chance at all that we may receive payment for the service, we do everything we possibly can to work through issues or delays with the VISN. Ultimately, however, if we are unable to obtain a definitive response from the VISN, the veteran may become financially responsible for payment. When that occurs, AMR will work directly with the veteran to establish a monthly payment plan, and we also will submit the claim to any other third party payer that may cover the service on their behalf. If, however, the veteran simply has no financial means to cover the cost of the service, the claim unfortunately may ultimately be referred to external collections. Once again, AMR does everything we can to avoid this from occurring, but other providers may have fewer options.

While many large ambulance companies are able to operate despite the VA's delinquent payments, for small ambulance companies, it is much more difficult to hold claims open without payment for long periods of time. Because large companies can normally establish policies for veterans that allow them to work much longer on obtaining payment from the VA and other third party payers before holding veterans personally responsible, they will show accounts that remain open on their data for sometimes over a year while they try to find a payment resolution. Small companies – particularly those that are in rural areas with a low volume of calls but the large overhead costs of maintaining an ambulance ready for response when needed – are in a much different situation. Because they have far smaller volumes, accounts cannot be held open for long periods of time or they will simply not be able to maintain their ability to stay in business. In these cases, companies may have no choice but to hold the veteran responsible much earlier in the billing cycle and provide them with a smaller number of choices or a shorter monthly payment plan period to resolve their debt. In many cases in these areas, veterans' claims are being referred to outside collection agencies much faster. This occurs even when the VA should be responsible for payment but simply does not respond in a timely manner. These companies have nowhere to turn and while none of them want to send a veteran to collections or cause them anxiety for a debt they should not be responsible for paying, the time it currently takes for the VA to process their ambulance claim simply cannot sustain them. Whenever possible, these small companies have begun to question whether they want to contract with VA facilities in their area to provide ambulance services to their patients. Small ambulance providers are hesitant to enter into any service agreements to provide service to these VA facilities when they know they won't receive timely reimbursement. This is beginning to cause access issues for veterans in many areas of the county.

Conclusion

We appreciate the Subcommittee's examination of the issue. While we were all hopeful that the Veterans Access, Choice and Accountability Act, which was signed into law last year, would help resolve these critical payment issues, unfortunately it has not. In fact, since the bill was signed into law, the problem has only gotten worse. The VA is already subject to prompt payment laws—laws the agency is not following. Respectfully, we submit that Congress needs to take more aggressive action to fix the VA's health care system and ensure that our nation's veterans receive the care they deserve.

AMR PBS Reports

Current VA Data (as of May 27, 2015)

All Net Balance by Date Of Last Bill-To Aging Bucket

All VA Claims By Contracted/Non-Contracted Status

| Contracted Status | Contract Combo | Trips | Total Net Balance | 0-30 Days(\$) | 31-60 Days(\$) | 61-90 Days(\$) | 91-120 Days(\$) | 121-150 Days(\$) | 151-180 Days(\$) | 181-364 Days(\$) | 365 Plus Days(\$) |
|-------------------|---------------------------------------|---------------|--------------------|--------------------|--------------------|-------------------|-----------------|------------------|-------------------|-------------------|-------------------|
| Contracted | 8950 - BT66300-VA NON CONT-PUGET SND | 190 | \$179,816 | \$57,221 | \$122,595 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | MW50 - BT59300-VA NON CONT- MEDICWEST | 362 | \$125,453 | \$92,489 | \$46,926 | \$13,962 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | No Contract Code | 603 | \$21,850 | \$148,472 | (\$34,351) | (\$7,333) | (\$21,731) | (\$9,678) | (\$22,763) | (\$10,050) | (\$20,716) |
| | HVA7 - BT60500-VA NON CONT-HEMET VALL | 6 | \$13,269 | \$13,269 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | VAC7 - BT60500-VA NON CONT-LOWA LINDA | 8 | \$12,248 | \$12,248 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | RA7 - BT60500-VA NON CONT-AMR RVRSDE | 5 | \$9,383 | \$7,452 | \$1,932 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | DS22 - CT66800-VA MED CENT - SPOKANE | 3 | \$8,228 | \$5,447 | \$2,781 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | SVA1 - BT65800-VA MEDICAL CTR | 5 | \$6,872 | \$6,872 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | VAVF - FB589A7 VETERANS ADMIN | 1 | \$4,713 | \$4,713 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | SVA7 - BT60500 - VA NON CONT -SPRINGS | 1 | \$3,538 | \$3,538 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | CVAM - FB54200 COATESVILLE VA MED CTR | 2 | \$2,883 | \$2,883 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | NIVA - FB56100 NEW JERSEY VA | 1 | \$2,292 | \$2,292 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | 9512 - FB549A4 DALLAS VA FEE FOR SERV | 1 | \$2,125 | \$0 | \$0 | \$0 | \$2,125 | \$0 | \$0 | \$0 | \$0 |
| | E522 - CT66800 VA MED CENT - SPOKANE | 1 | \$1,957 | \$0 | \$1,957 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | IL93 - BT657A5 MARION VA BENE TRAVEL | 1 | \$1,536 | \$1,536 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | 5503 - PEACEHEALTH SW HOSPICE | 2 | \$723 | \$723 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | 13 - SUBSCRIPTION | 1 | \$250 | \$0 | \$250 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | B082 - STANFORD UNIVERSITY HOSPITAL | 1 | \$113 | \$0 | \$113 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | Total Contracted | 1,154 | \$592,154 | \$592,154 | \$147,054 | (\$21,133) | \$35,606 | (\$9,678) | (\$22,763) | (\$10,050) | (\$20,716) |
| Non-Contracted | J07E - CT67300 JAMES A HALEY | 4,889 | \$622,694 | \$604,646 | \$18,676 | (\$53) | \$0 | (\$105) | (\$36) | (\$307) | (\$127) |
| | AAALD - CT66800 DC VA MED CENTER | 852 | \$518,155 | \$169,505 | \$150,069 | \$48,416 | \$70,064 | \$76,611 | \$482 | \$2,136 | \$873 |
| | 1802 - CT612A4 VA NORTHERN CA HEALTH | 115 | \$362,617 | \$203,645 | \$154,300 | \$0 | \$858 | \$1,977 | (\$930) | \$2,766 | \$0 |
| | VATD - CT68900 WEST HAVEN CT VA | 786 | \$313,988 | \$88,902 | \$94,192 | \$75,825 | \$54,986 | \$0 | \$0 | \$84 | \$0 |
| | AO43 - CT65700 JEFFERSON BARRACKS VA | 1,338 | \$304,428 | \$191,931 | \$111,446 | \$892 | \$0 | \$0 | \$0 | \$0 | \$159 |
| | 1800 - CT64000 VA PALO ALTO HEALTH CA | 100 | \$279,113 | \$123,140 | \$148,684 | \$0 | \$3,654 | \$1,129 | \$0 | \$2,506 | \$0 |
| | 1809 - CT64000 VA PALO ALTO HEALTH CA | 74 | \$239,653 | \$110,781 | \$106,123 | \$5,725 | \$0 | \$3,680 | \$13,344 | \$0 | \$0 |
| | 1829 - CT612A4 VA NORTHERN CA HEALTH | 77 | \$187,564 | \$44,669 | \$30,423 | \$0 | \$0 | \$22,592 | \$11,154 | \$78,725 | \$0 |
| | DVAK - CT596A4 KENTUCKY VA | 557 | \$174,899 | \$32,841 | \$51,394 | \$57,237 | \$33,426 | \$0 | \$0 | \$0 | \$0 |
| | J07A - CT67300 JAMES HALEY | 572 | \$172,614 | \$96,655 | \$76,851 | \$0 | \$0 | \$0 | \$211 | \$0 | (\$1,103) |
| | RO1A - CT54800 WPB VA O-20 MLS | 464 | \$150,968 | \$27,775 | \$11,555 | \$288 | \$60,488 | \$29,597 | \$19,498 | \$1,480 | \$287 |
| | 1801 - CT66200 VA SAN FRANCISCO MED C | 48 | \$136,575 | \$60,721 | \$66,636 | \$4,854 | \$4,364 | \$0 | \$0 | \$0 | \$0 |
| | 5053 - CT45900 VA HAWAII | 77 | \$100,401 | \$29,124 | \$58,600 | \$1,769 | \$6,637 | \$3,797 | (\$143) | \$618 | \$0 |
| | Total Non-Contracted | 11,544 | \$5,771,741 | \$3,952,154 | \$1,477,054 | (\$21,133) | \$35,606 | (\$9,678) | (\$22,763) | (\$10,050) | (\$20,716) |

AMR PBS Reports

Current VA Data (as of May 27, 2015)

All Net Balance by Date Of Last Bill-To Aging Bucket

All VA Claims By Contracted/Non-Contracted Status

| Contracted Status | Contract Combo | Trips | Total Net Balance | 0-30 Days(\$) | 31-60 Days(\$) | 61-90 Days(\$) | 91-120 Days(\$) | 121-150 Days(\$) | 151-180 Days(\$) | 181-364 Days(\$) | 365 Plus Days(\$) |
|-------------------|---------------------------------------|-------|-------------------|---------------|----------------|----------------|-----------------|------------------|------------------|------------------|-------------------|
| | V8 - CT52000 BILOXI VA CENTER | 285 | \$87,956 | \$42,666 | \$45,243 | (\$300) | \$0 | \$0 | \$0 | \$390 | (\$44) |
| | 7015 - CT589A5 COLMERY-O'NEIL VAMC | 159 | \$69,009 | \$31,373 | \$22,039 | \$15,597 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | 7805 - CT58900 KANSAS CITY VA | 117 | \$63,812 | \$18,075 | \$40,226 | \$4,965 | \$0 | \$547 | \$0 | \$0 | \$0 |
| | R01B - CT54800 WPB VA 21-100 MLS | 74 | \$44,387 | \$16,492 | \$9,086 | (\$54) | \$16,135 | (\$82) | (\$1,679) | \$2,843 | \$1,647 |
| | 9854 - CT44200 CHEYENNE VA MED CENTER | 41 | \$43,428 | \$14,090 | \$15,466 | \$17,875 | (\$1,076) | \$0 | \$0 | (\$2,926) | \$0 |
| | 1819 - CT66200 VA SAN FRANCISCO MED C | 18 | \$40,319 | \$20,904 | \$9,371 | \$0 | \$6,100 | \$0 | \$0 | \$0 | \$0 |
| | 4522 - CT66800 VA MED CENT - SPOKANE | 89 | \$32,174 | \$23,446 | \$6,645 | \$1,466 | \$313 | \$304 | \$0 | \$0 | \$0 |
| | 700A - CT589A6 EISENHOWER VAMC | 27 | \$29,789 | \$5,890 | \$16,738 | \$7,161 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | 1820 - CT66200 VA SAN FRANCISCO MED C | 13 | \$29,112 | \$15,165 | \$13,947 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | AG43 - CT65700 JEFFERSON BARRACKS VA | 119 | \$27,030 | \$19,683 | \$7,346 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | FLVA - CT55400 VA ECHCS | 75 | \$21,596 | \$15,554 | \$5,911 | \$131 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | 7115 - CT589A5 COLMERY-O'NEIL VAMC | 23 | \$18,415 | \$3,077 | \$7,822 | \$7,515 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | 001B - CT54600 BROWARD VA 21-100 | 31 | \$16,605 | \$16,600 | \$526 | \$0 | \$0 | \$75 | \$0 | (\$520) | (\$119) |
| | 001A - CT54600 BROWARD VA 0-20 | 47 | \$15,741 | \$16,033 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | 4522 - CT66800 VA MED CENT - SPOKANE | 5 | \$12,644 | \$3,800 | \$8,844 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | X39A - CT54600 MIAMI VA 0-20 | 27 | \$8,635 | \$3,665 | \$0 | \$0 | \$0 | \$0 | \$0 | \$4,970 | \$0 |
| | V05A - CT54600 MIAMI VA 0-20 | 19 | \$7,928 | \$7,582 | \$0 | \$346 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | R01G - CT54800 WPB VA 21-100 MLS | 16 | \$5,387 | \$3,075 | \$2,990 | \$0 | \$0 | (\$416) | \$184 | (\$447) | \$0 |
| | 7005 - CT58900 KANSAS CITY VA | 8 | \$4,254 | \$2,188 | \$2,066 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | 8522 - CT66800 VA MED CENT - SPOKANE | 1 | \$3,929 | \$0 | \$0 | \$0 | \$0 | \$0 | \$3,929 | \$0 | \$0 |
| | R01H - CT54800 WPB VA OVR 100 MLS | 2 | \$3,085 | \$3,085 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | X39B - CT54600 MIAMI VA 21-100 | 5 | \$2,293 | \$1,804 | \$0 | \$0 | \$0 | \$0 | \$0 | \$489 | \$0 |
| | X39C - CT54600 MIAMI VA 100+ | 1 | \$2,229 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$2,229 | \$0 |
| | V05B - CT54600 MIAMI VA 21-100 | 6 | \$2,141 | \$1,897 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$244 |
| | R01F - CT54800 WPB VA 0-20 MLS | 15 | \$1,403 | \$707 | \$707 | \$0 | \$0 | (\$5) | (\$18) | \$11 | \$0 |
| | R01C - CT54800 WPB VA OVR 100 MLS | 2 | \$1,366 | \$1,520 | (\$155) | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| NON-CONTRACTED | | 1,617 | \$3,683,316 | \$2,077,760 | \$1,423,145 | \$306,655 | \$355,940 | \$13,645 | \$16,597 | \$4,068 | \$1,516 |
| | T200 - VA NON CONTRACTED - SO CA | 1,305 | \$1,003,013 | \$339,291 | \$257,436 | \$112,717 | \$75,747 | \$50,367 | \$70,494 | \$94,325 | \$2,636 |
| | N500 - FB55300 VA NON CONT - N LAS VE | 919 | \$908,709 | \$367,465 | \$157,567 | \$67,910 | \$84,259 | \$62,945 | \$74,814 | \$91,604 | \$2,145 |
| | N501 - FB00000 VA NON CONT - OREGON | 1,619 | \$699,570 | \$173,239 | \$147,511 | \$143,680 | \$102,674 | \$51,080 | \$31,837 | \$41,015 | \$7,534 |
| | VACT - FB68900 NEWINGTON CT VA | 674 | \$581,202 | \$124,771 | \$113,550 | \$132,737 | \$85,509 | \$42,775 | \$22,323 | \$32,058 | \$27,478 |
| | T501 - VA NON CONTRACTED - TEXAS | 869 | \$380,436 | \$105,665 | \$63,362 | \$59,805 | \$47,272 | \$28,488 | \$12,679 | \$51,814 | \$10,908 |
| | N200 - FB00000 VA NON CONT - WA | 987 | \$373,397 | \$72,758 | \$60,534 | \$73,374 | \$56,001 | \$19,651 | \$11,545 | \$38,238 | \$41,297 |
| | 726 - FB60800 MANCHESTER VAMC | 152 | \$328,196 | \$61,454 | \$61,648 | \$48,218 | \$39,046 | \$38,583 | \$9,314 | \$59,985 | \$9,947 |

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All VA Facilities - Current AR

Current VA Data (as of May 27, 2015)
All Net Balance by Date Of Last Bill-To Aging Bucket
All VA Claims By Contracted/Non-Contracted Status

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AMR PBS Reports

Current VA Data (as of May 27, 2015)

All Net Balance by Date Of Last Bill-To Aging Bucket

All VA Claims By Contracted/Non-Contracted Status

| Contracted Status | Contract Combo | Trips | Total Net Balance | 0-30 Days(\$) | 31-60 Days(\$) | 61-90 Days(\$) | 91-120 Days(\$) | 121-150 Days(\$) | 151-180 Days(\$) | 181-364 Days(\$) | 365 Plus Days(\$) |
|-----------------------------|---------------------------------------|--------------|--------------------|--------------------|--------------------|--------------------|------------------|------------------|------------------|------------------|-------------------|
| | T500 - VA NON CONTRACTED - OKLAHOMA | 43 | \$21,713 | \$5,346 | \$2,379 | \$4,027 | \$371 | \$3,104 | \$3,066 | \$2,973 | \$448 |
| | D029 - FB52000 SOUTH CENTRAL FEE UNIT | 59 | \$21,391 | \$12,020 | \$3,386 | \$4,526 | \$1,099 | \$629 | \$0 | (\$187) | (\$83) |
| | 7AAS - FB58900 KANSAS CITY VA | 42 | \$19,817 | \$8,430 | \$5,354 | \$5,780 | \$1,094 | \$0 | (\$297) | (\$544) | \$0 |
| | RENV - FB65400 VA NON CONT - SIERRA N | 24 | \$16,727 | \$4,399 | \$5,731 | \$3,213 | \$1,502 | \$1,882 | \$0 | \$0 | \$0 |
| | FRNV - FB57000 VA NON CONT - CENTRAL | 31 | \$15,436 | \$2,937 | \$3,292 | \$3,074 | \$1,610 | \$1,606 | \$918 | \$0 | \$0 |
| | HAVA - FB59000 HAMPTON VA MED CENTER | 21 | \$14,897 | \$3,080 | \$47 | \$9,273 | \$0 | \$2,498 | \$0 | \$0 | \$0 |
| | BEDV - BT51800 BEDFORD VA HOSPITAL | 8 | \$11,212 | \$512 | \$1,507 | \$0 | \$0 | \$0 | \$4,978 | \$4,215 | \$0 |
| | VAMC - FB65000 PROVIDENCE VAMC | 5 | \$10,803 | \$0 | \$0 | \$2,447 | \$1,035 | \$0 | \$6,667 | \$1,690 | \$0 |
| | X130 - FB54800 WPB VA | 15 | \$9,599 | \$0 | \$3,308 | \$1,613 | \$0 | \$0 | \$1,423 | \$1,373 | \$849 |
| | VWVRV - BT52300 WEST ROXBURY VA | 2 | \$8,760 | \$0 | \$8,760 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | B32A - BT51600 BAY PINES VA HOSP | 10 | \$6,037 | \$2,863 | \$1,961 | \$2,244 | \$1,475 | \$0 | \$0 | (\$1,506) | \$0 |
| | HVR - FB68900 ROCKY HILL VA HOSPITAL | 8 | \$6,908 | \$0 | \$0 | \$0 | \$0 | \$3,436 | \$1,808 | \$826 | \$838 |
| | PVVA - FB65000 PROVIDENCE VAMC | 4 | \$5,663 | \$0 | \$0 | \$0 | \$0 | \$0 | \$2,470 | \$3,192 | \$0 |
| | J07D - FB67300 JAMES A HALEY VA HOSP | 8 | \$5,261 | \$5,261 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | A267 - BT589A00 HARRY TRUMAN VA HOSP | 4 | \$4,857 | \$844 | \$4,013 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | XAZ5 - FB54600 MIAMI VA | 12 | \$4,493 | \$3,024 | \$0 | \$750 | \$720 | \$0 | \$0 | \$0 | \$0 |
| | IAVA - FB636A8 IOWA VA MED CENTER | 7 | \$4,416 | \$3,373 | \$619 | \$424 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | VTVA - BT40500 WHITE RIVER JUNCT VA | 1 | \$3,804 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$3,804 |
| | RVMC - FB65200 RICHMOND VA MED CENTER | 2 | \$3,332 | \$0 | \$0 | \$3,332 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | BEVA - FB51800 BEDFORD VA HOSPITAL | 1 | \$3,325 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$3,325 |
| | VATV - DEPT OF VETERANS AFFAIRS | 1 | \$3,092 | \$3,092 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | ROJE - FB54800 WPB VA | 9 | \$2,769 | \$1,064 | \$1,012 | \$0 | \$0 | \$0 | \$175 | \$520 | \$0 |
| | S123 - BARNES-JEWISH HOSPITAL POLR | 1 | \$2,235 | \$0 | \$2,235 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | DVAI - FB636A6 DEPT OF VET AFFAIRS | 1 | \$1,956 | \$0 | \$1,956 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | IL89 - FB657A4 PERSHING VA FEE FOR SV | 2 | \$1,608 | \$980 | \$629 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | V05G - FB54600 MIAMI VA MED CENTER | 3 | \$1,224 | \$366 | \$0 | \$0 | \$858 | \$0 | \$0 | \$0 | \$0 |
| | V055 - FB630A5 NEW YORK HARBOR VA | 1 | \$1,034 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$1,034 |
| | O01D - FB54600 BROWARD VA CLINIC | 4 | \$929 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$516 | \$413 |
| | BAMC - BROOK ARMY MEDICAL CENTER | 2 | \$809 | \$330 | \$480 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | PAVA - PENNSYLVANIA DEPT OF VA AFFAIR | 1 | \$737 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | VBVH - BT523A5 BROOKTON VA | 1 | \$706 | \$706 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | X217 - FB54600 BROWARD VA | 2 | \$272 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$272 | \$0 |
| | VAM2 - BT52300 JAMAICA PLAIN | 1 | \$256 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$256 | \$0 |
| NON-CONTRACTED Total | | 11243 | \$7,910,007 | \$2,457,111 | \$1,676,340 | \$1,092,731 | \$677,228 | \$463,508 | \$305,130 | \$550,381 | \$186,383 |

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All VA Facilities - Current AR

AMR PBS Reports
 Current VA Data (as of May 27, 2015)
 All Net Balance by Date Of Last Bill-To Aging Bucket
 All VA Claims By Contracted/Non-Contracted Status

| Contracted Status | Contract Combo | Trips | Total Net Balance | 0-30 Days(S) | 31-60 Days(S) | 61-90 Days(S) | 91-120 Days(S) | 121-150 Days(S) | 151-180 Days(S) | 181-244 Days(S) | 245 Plus Days(S) |
|-------------------|----------------|--------|-------------------|--------------|---------------|---------------|----------------|-----------------|-----------------|-----------------|------------------|
| Grand Total | | 23,624 | \$12,065,560 | \$4,888,992 | \$3,114,238 | \$1,325,704 | \$943,566 | \$597,473 | \$328,565 | \$735,728 | \$167,483 |

Testimony of Greg Hufstetler
 Vice President Reimbursement & Regulatory Affairs
 Reimbursement Technologies, Inc. (RTI)—a Subsidiary of EmCare, Inc. (“EmCare”)

House Committee on Veterans’ Affairs
 Subcommittee on Health
 June 3, 2015

Mr. Chairman,

Thank you for giving me the opportunity to submit written testimony as part of the Committee’s oversight hearing on the ability of the Department of Veterans Affairs to comply with the Prompt Pay Act and efficiently and accurately reimburse non-VA providers. As the Vice President for Reimbursement and Regulatory Affairs for EmCare’s billing subsidiary, Reimbursement Technologies, Inc. (RTI), I am responsible for managing a large professional staff (over 60) that supports many of the regulatory and business functions of over 600 EmCare emergency department physician groups nationwide.

More specifically, RTI bills all responsible parties, including third party insurers like the Department of Veterans Affairs, for EmCare’s current fifteen million annual patient encounters across 650 healthcare facilities in 41 states and the District of Columbia. While EmCare’s largest medical specialty is hospital-based Emergency Medicine (emergency departments), other specialties include Hospital Medicine (inpatient services), Anesthesiology, Surgery, and Radiology.

EmCare’s physicians and non-physician providers (physician assistants and nurse practitioners) provide needed services to over 30,000 of our nation’s veterans each year. The vast majority of these services are treatments in hospital emergency departments to veterans seeking immediate care. Such care is available every shift of every day of every year in these locations for our deserving veterans. **In this testimony I wish briefly to describe our on-going difficulties and the virtual impasse we have reached in obtaining payment for these services from the Department of Veterans Affairs.**

I. Inability to obtain payments for services provided

Starting in the fourth quarter of 2013 and continuing to today, EmCare has been unable to obtain virtually any payments from the Veterans Health Administration. This delay in payment has occurred even though all claims, with attached medical records, are submitted in a timely manner. The table below summarizes EmCare’s outstanding accounts receivable with the Veterans Health Administration since 2012:

| Year | Veterans Treated without Payment | Outstanding Accounts Receivable |
|-----------------|----------------------------------|---------------------------------|
| 2012 | 1,683 | \$1,026,383 |
| 2013 | 5,141 | \$3,220,989 |
| 2014 | 21,573 | \$15,593,875 |
| 2015 thru April | 30,875 | \$25,608,073 |
| | 59,272 | \$45,449,320 |

II. Current Dysfunctional, Fragmented Claims Processing System

Physicians serving the nation's veterans are currently required to be enrolled as "vendors" at **both** the local VA level **and** at the national VA level. It is our experience that each local VA hospital has developed unique enrollment forms and procedures. A single, national standard does not exist. Nor are local enrollment procedures made available on-line, or in any other workable manner. Such protocols can only be obtained by interacting with each of the hundreds of VA hospitals—by waiting on hold for hours per week, hoping that the VA respondent can provide a correct answer when one is given.

Further, physicians need to be enrolled with each patient's "home" or local VA center—besides being a "vendor" with the VA district in which the treatment occurred. This results in an unworkable situation when veterans travel and seek emergency care. The following scenario is an example of what one of EmCare's emergency physicians could potentially face during a given year while providing needed services to a random array of veterans.

- A physician working in Florida enrolls with his local VA center
- During the year the physician treats 50 veterans who reside out of the area, each from a different local VA office.
- **50 additional enrollments need to be completed**

III. Recommended Improvement Plan

Of the hundreds of private, state-supported and federally-supported insurers that EmCare submits claims to each year, the Medicare program is one of the most efficient and problem-free payers in terms of claims submission and payment. The Medicare claims processing and enrollment functions are contracted out to private companies through a competitive bidding process.

- (1) Moving to a single, national processor or a few regional processors similar to the Medicare program's Medicare Administrative Contractors (MACs) would eliminate the need for hundreds of local VA hospitals to be involved in the review and approval of claims for services provided outside of the VA hospital network.
- (2) Eliminating the need for multiple "vendor" enrollments is a short-term action that should be taken to allow the growing backlog of outstanding claims to be adjudicated in a timely manner. A single enrollment with the national VA processing center in Texas should allow a physician to be enrolled and approved for payment at all VA locations.

Immediate action needs to be taken to address this lack of payment to our EmCare physicians who have treated veterans for many years during their time of need, and in fact stand ready to continue such services even in the face of these discouraging and distressing problems in the VA payment system.

If you should want any further information, please contact me as follows:

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